

Date \_\_\_\_\_

**TRES LUNAS MIDWIFERY**  
**Client Information**

Name _____	Age _____	DOB _____
Maiden Name _____	State of Birth (client) _____	(partner) _____
Partner/Support _____	Age _____	DOB _____
Address _____		
City _____	State _____	Zip _____
Phone ( ) _____	Wk ( ) _____	OK to use? __Y __N
Other useful numbers _____		Partner status _____

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Client:** Occupation \_\_\_\_\_ Ethnicity \_\_\_\_\_ Yrs. School \_\_\_\_\_

**Partner:** Occupation \_\_\_\_\_ Ethnicity \_\_\_\_\_ Yrs. School \_\_\_\_\_

**Insurance:** \_\_\_\_\_ # \_\_\_\_\_

**Back-up plan:** Practice: \_\_\_\_\_ # \_\_\_\_\_ Hospital \_\_\_\_\_

Received previous care during this pregnancy? \_\_\_\_\_ # apts. \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Why did you choose midwives? \_\_\_\_\_

\*\*\*\*\*

**Menstrual History**

Menarch \_\_\_\_\_ Length \_\_\_\_\_ # Days of flow \_\_\_\_\_ Regular? \_\_\_\_\_

Describe your flow: \_\_\_\_\_ Do you have PMS/Cramps? Describe \_\_\_\_\_

Have you had periods of time when you didn't menstruate or had unusual periods? \_\_\_\_\_

Was this a planned pregnancy? \_\_\_\_\_ Did you have any problems getting pregnant? \_\_\_\_\_

Have you used oral contraceptives recently? \_\_\_\_\_ If so, when did you stop? \_\_\_\_\_

Were you using birth control when you conceived? What form? \_\_\_\_\_

Birth Control History (what and when?): \_\_\_\_\_

\*\*\*\*\*

LMP \_\_\_\_\_ Preg. Test U/B? \_\_\_\_\_ Sonogram? Date \_\_\_\_\_

Was it normal? \_\_\_\_\_ Date(s) \_\_\_\_\_ Other? Date \_\_\_\_\_

Conception date \_\_\_\_\_ Results \_\_\_\_\_ Due Date by sonos \_\_\_\_\_

Sure of dates? \_\_\_\_\_ Quickening? \_\_\_\_\_

**EDD** \_\_\_\_\_

Date \_\_\_\_\_

**Medical History**

Diabetes/sugar problems _____	Asthma _____	Operations _____
Gastrointestinal problems _____	Allergies _____	Hemorrhage _____
Rubella _____	Thyroid Probs. _____	Blood Transfusion _____
Chicken Pox _____	Anemia _____	Herpes _____
Rheumatic Fever _____	Liver disease/Hepatitis _____	Other STDs _____
Kidney Disease _____	Circulatory problems _____	PID _____
UTI _____	Diabetes _____	Gynecological Procedures _____
Hypertension _____	Cancer/growths _____	Uterine Abnormality _____
Severe Headaches _____	Breast lumps/surgery _____	Blood disorders _____
Epilepsy _____	Back problems _____	Yeast Infections _____
Cardiac Disease _____	Arthritis/Rheumatism _____	Exposure to Xrays _____
Tuberculosis _____	Accidents _____	Emotional issues _____
Thrombophlebitis _____	Drug rx _____	Eating disorder _____

Do you know your HIV status? \_\_\_\_\_

History of sexual or physical abuse? \_\_\_\_\_

Any other medical problems/issues not listed \_\_\_\_\_

*Meals:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

.....  
Partner's/FOB's medical issues: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Lifestyle & Habits**

Do you or your partner:

	<u>Client</u>	<u>Partner</u>	<u>Comments</u>
smoke tobacco	___	___	_____
smoke marijuana	___	___	_____
drink alcohol	___	___	_____
take prescription drugs	___	___	_____
drink caffeinated beverages	___	___	_____
use medicinal herbs	___	___	_____
been exposed to toxins	___	___	_____

\*\*\*\*\*

Do you have a history of drug use/abuse? Have you ever been in a recovery program?

Client \_\_\_\_\_ Partner \_\_\_\_\_

Do you have any pets? \_\_\_\_\_ Are you currently eating raw meat? \_\_\_\_\_

Are you taking any vitamins or supplements? \_\_\_\_\_

How would you describe your diet? \_\_\_\_\_

\_\_\_\_\_

What do you do for exercise? \_\_\_\_\_

Do you have a religion or spiritual practice? \_\_\_\_\_

**Pregnancy History** Gravida \_\_\_\_\_ Para \_\_\_\_\_ SAB \_\_\_\_\_ TOP \_\_\_\_\_ Date \_\_\_\_\_ Living \_\_\_\_\_

Topic	1 <sup>st</sup> pregnancy	2 <sup>nd</sup> pregnancy	3 <sup>rd</sup> pregnancy
Name			
Date of birth			
Due Date			
Location of birth			
Induced? How?			
C-sec? Cause?			
1 <sup>st</sup> sign of labor			
Length of labor			
Length of push			
Forceps/Vacuum			
Medication?			
Tear/epis/suture			
Hemorrhage?			
Complications Mother?			
Complications Baby?			
Abnml. Placenta			
Baby weight			
BF? Duration			
PP problems?			

Comments about prenatal, birth and pp experience: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History**

Please mark if anyone in your immediate family (parents, siblings, grandparents) have any of the following:

Diabetes \_\_\_\_\_ Respiratory illness \_\_\_\_\_ Tuberculosis \_\_\_\_\_  
 Cancer/growths \_\_\_\_\_ Epilepsy \_\_\_\_\_ Cardiac disease \_\_\_\_\_  
 Thyroid disorder \_\_\_\_\_ Kidney disease \_\_\_\_\_ Circulatory problems \_\_\_\_\_  
 Genetic disorders \_\_\_\_\_ High blood pressure \_\_\_\_\_ Twins \_\_\_\_\_  
 Any other medical problems/issues not listed \_\_\_\_\_  
 Explanation: \_\_\_\_\_

Date \_\_\_\_\_

**Family Obstetric History**

How many times was your mother pregnant? \_\_\_\_\_ How many children did she have? \_\_\_\_\_  
How many are living now? \_\_\_\_\_ Did she have any miscarriages? \_\_\_\_\_  
Were there any complications in any of her pregnancies? If so please describe. \_\_\_\_\_  
Did your mother take DES while she was pregnant with you? \_\_\_\_\_ What was your birth weight? \_\_\_\_\_  
Did she give birth at home or in the hospital? \_\_\_\_\_ Did she breastfeed? \_\_\_\_\_  
What is her attitude toward birth now? \_\_\_\_\_  
Has anyone else in your family had complications during pregnancy or birth? \_\_\_\_\_  
Comments/Concerns \_\_\_\_\_

**Present Pregnancy**

During this pregnancy have you experienced any of the following:

Abd. Pain/Cramp _____	Varicosities _____	Bruising _____
Leg Cramps _____	Const/Diarrhea _____	Bleeding gums _____
Bleeding/Spotting _____	Hemorrhoids _____	Resp. Probs _____
UTI _____	Extreme Fatigue _____	Chest pain _____
Fever _____	Headaches _____	Rashes _____
Naus/Vom _____	Swelling _____	Pigment change _____
Poor Appetite _____	Visual probs. _____	Heartburn _____
Pica/Cravings _____	Dizziness _____	Vag. Infx. _____
	Fainting _____	

Comments: \_\_\_\_\_

**Physical Exam**

Respirations \_\_\_\_\_ Temp \_\_\_\_\_ Height \_\_\_\_\_ Reflexes \_\_\_\_\_  
Vaginal Exam: Last Pap: Date \_\_\_\_\_ Results \_\_\_\_\_  
Cervix \_\_\_\_\_ Uterus \_\_\_\_\_ Ovaries \_\_\_\_\_ Tissue \_\_\_\_\_  
Perineum \_\_\_\_\_ Signs of infx \_\_\_\_\_

**Pelvimetry**

Diag. Cong. \_\_\_\_\_ Pubic Arch \_\_\_\_\_ Shape of sacrum \_\_\_\_\_  
Sacro-sciatic notch \_\_\_\_\_ Ischial spines \_\_\_\_\_ Interspinous diam. \_\_\_\_\_  
Sacral promontory \_\_\_\_\_ Ischial tuberosities \_\_\_\_\_ Side walls \_\_\_\_\_  
Other findings \_\_\_\_\_

**Breast Exam**

Concerns: \_\_\_\_\_ Self-exam: \_\_\_\_\_  
Description of findings: \_\_\_\_\_