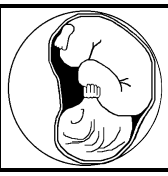
CLIENT REGISTRATION AND HEALTH HISTORY — Page 1

This form helps us to document important health history, complete the baby's birth certificate, and file insurance. Further discussion may be necessary to clarify information contained in this document. Your information is kept confidential.



Home Birth Midwifery Service℠
NARM Certified Professional Midwives ~ VA Licensed
Kim Mosny, CPM, LM
(901) 292-4876 / (804) 651-0608
13541 East Boundary Road, Suite 101
Midlothian, VA 23112

MOTHER'S FULL LEGAL NAME LAST FIRST MIDDLE MAIDEN?					TODAY'S DATE
RACE	RELIGIOUS PREF.	YRS OF EDUC	MARITAL STATUS	INSIDE CITY? ☐ YES ☐ NO	DATE OF BIRTH
STREET ADDRESS					STATE/COUNTRY OF BIRTH
CITY/STATE ZIP/COUNTY CITY STATE ZIP CODE COUNTY					HOME/CELL PHONE
SSN — —		OCCUPATION/ INDUSTRY			WORK PHONE
FATHER OF BABY FULL LEGAL NAME LAST FIRST MIDDLE JR/SR/etc...					DATE OF BIRTH
RACE	RELIGION	YRS OF EDUC	MARRIED TO BABY'S MOTHER? ☐ YES ☐ NO		STATE/COUNTRY OF BIRTH
ADDRESS (IF DIFFERENT)					HOME/CELL PHONE
SSN — —		OCCUPATION/ INDUSTRY			WORK PHONE
MOTHER'S PARTNER/HUSBAND (IF DIFFERENT FROM FATHER) FIRST M.I. LAST					PHONE

METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ CREDIT ☐ INSUR (All clients must pay in FULL by 36 wks.) (Insurance will be filed AFTER the birth.)				EMERGENCY CONTACT: RELATION: _____ PHONE:_____
INSURANCE COMPANY		POLICY/ GRP #		NOTE: Clients seeking insurance reimbursement should provide a photo copy of their insurance card (front & back).
CLAIM ADDRESS		POLICY HOLDER		HBMS is NOT responsible for insurance negotiations after the claim has been filed. An additional charges will apply for repeat billings.
CITY/ST ZIP		CUST SERV PHONE		

EMAIL ADDRESSES	

FAMILY HISTORY — Indicate if anyone in your immediate family has ever had any of these conditions; who and when.	FATHER OF BABY — Indicate if the baby's father has ever had any of these conditions; when.	YOUR MOTHER'S HISTORY — Indicate the following infomation, regarding YOUR mother's pregnancy history.
☐ High Blood Pressure ☐ Cancer ☐ Diabetes ☐ Twins ☐ Severe Emotional Problems ☐ Alcohol/Drug Abuse ☐ Other	☐ Sexually transmitted diseases ☐ Herpes — ☐ Genital, 1st outbreak: _____ ☐ Oral, site of outbreaks: _____ ☐ Severe Emotional Problems ☐ Alcohol/Drug Abuse ☐ Tobacco Use ☐ Other	☐ Number of pregnancies: ☐ Number of live births: ☐ Number of miscarriages: ☐ Complications? ☐ Your birth weight: _____lbs. _____oz.

PREVIOUS PREGNANCY OUTCOMES — Please complete this table regarding your OWN pregnancy history (in descending order from most recent to first)

Date	# Weeks	Birth / Miscarriage / Termination	Comments / Procedures / Medications / Complications / Breastfed (how long?)

Please answer the following important questions. While private in nature, these issues help us determine your RISK FACTORS for having a safe home birth.

☐ YES ☐ NO Have you or the Father of the Baby (FOB) ever had a baby with a birth defect or mental retardation?
☐ YES ☐ NO Do you or the FOB have any family member(s) with birth defects or conditions diagnosed as genetic or inherited?
☐ YES ☐ NO Are you and the FOB related by blood? (i.e. cousins)
☐ YES ☐ NO Are you or the FOB from any of these ethnical groups? ☐ Jewish ☐ Black/African ☐ Asian ☐ Mediterranean
☐ YES ☐ NO Have you or the FOB ever had hepatitis (A, B, C) or jaundice?
☐ YES ☐ NO Have you ever used INTRAVENOUS (I.V.) drugs OR ever had a blood transfusion? If YES, explain: _____
☐ YES ☐ NO Do you think you are AT RISK for having a baby with a birth defect/genetic disorder? If YES, explain: _____
☐ YES ☐ NO Do you think you are AT RISK for HIV / AIDS? If YES, explain: _____
☐ YES ☐ NO Have you ever experienced dramatic fluctuations in your weight?
☐ YES ☐ NO Do you CURRENTLY have or have HAD anorexia, bulemia, or other eating disorders? If YES, explain: _____
☐ YES ☐ NO Is there anything about your sexuality that we should know? If YES, explain: _____
☐ YES ☐ NO Do you CURRENTLY have or have HAD severe emotional problems? If YES, explain: _____
☐ YES ☐ NO Do you CURRENTLY take or have taken ANY medication for psychological problems? If YES, when & what? _____
☐ YES ☐ NO Have you ever been told, or do YOU think, you have ever used alcohol or drugs excessively? If YES, explain: _____
☐ YES ☐ NO Are you CURRENTLY or have you EVER been in an ABUSIVE relationship? (physical, sexual, emotional, or other abuse) If YES, please explain:_____
_____
_____

CLIENT REG / HEALTH HISTORY — Page 2

MEDICAL HISTORY: Indicate if you have had any of these & when?

☐ Severe headaches _____
☐ Eye/vision problems _____
☐ Ear/hearing problems _____
☐ Dental/gum problems _____
☐ Thyroid problems _____
☐ Rheumatic fever _____
☐ Anemia/Sickle Cell _____
☐ Blood clotting problems ____
☐ Hemorrhage _____
☐ High blood pressure _____
☐ Heart problems _____
☐ Lung/resp. problems _____
☐ Tuberculosis _____
☐ Asthma _____
☐ Varicose veins _____
☐ Skin disorders _____
☐ Chicken pox/Shingles _____
☐ German Measles (Rubella) _____
☐ Stomach problems _____
☐ Ulcers _____
☐ Bowel problems/Colitis _____
☐ Blood in stool _____
☐ Gall bladder problems _____
☐ Liver problems _____
☐ Hepatitis (A, B, C) _____
☐ Diabetes _____
☐ Hypoglycemia _____
☐ Kidney problems _____
☐ Urinary infections (UTI) _____
☐ Urinary surgery _____
☐ Urethral dilation _____
☐ Aching joints _____
☐ Pelvic/back injuries _____
☐ Neurologic/Seizures _____
☐ Cancer _____
☐ Hospitalizations _____
☐ Surgeries _____
☐ Other _____

GYNECOLOGICAL HISTORY:

Age @ 1st period _____
Cycle length (circle) ~ 24 28 30 32
Regular? ☐ Yes ☐ No, irregular
Duration (circle) ~ 3 4 5 6+ days
Painful/cramping? ☐ Yes ☐ No
Last Pap? _____ - _____ - _____
Ever Abnrml Pap? ☐ No ☐ Yes
If Yes, when: ____ - ____ - _____
Explain details:
_____

☑ Yes, if YOU NOW HAVE or HAD any of these/when: ☐ NO.

☐ Vaginal yeast _____
☐ Trichomonas _____
☐ Group B Strep (GBS) _____
☐ Bacterial Vaginosis (BV) ____
☐ Chlamydia _____
☐ Gonorrhea (GC) _____
☐ Syphillis _____
☐ PID/Pelvic infections_____
☐ Genital Sores _____
☐ Condyloma _____
☐ HPV (Genital warts) _____
☐ Herpes: Simplex 1 - ☐ (Oral)
Simplex 2 - ☐ (Genital)
First outbreak: ___ - ___ - ___
☐ Breast lump(s) _____
☐ Breast surgery _____
☐ Cervicitis _____
☐ Cervical polyp(s) _____
☐ LEAP procedure _____
☐ Cervical surgery _____
☐ Cervical cerclage _____
☐ Ovarian cyst(s) _____
☐ Ovarian surgery _____
☐ Fibroids _____
☐ Endometriosis _____
☐ Abnml uterine bleeding _____
☐ Uterine scraping (D&C) _____
☐ Uterine surgery _____
☐ Infertility _____
☐ Infertility treatment _____
☐ Other _____
_____

Please indicate if your have ever had an INFANT with the following:

☐ Group B Strep disease _____ ☐ Trush (yeast in mouth) _____

Please indicate if you have the following at your home:

☐ Yes ☐ No — Telephone
☐ Yes ☐ No — Washer / Dryer
☐ Yes ☐ No — Pets, _____
_____

Please use the space below to share any particular ethnic, cultural, religious / spiritual, social, or family preferences regarding your care during your pregnancy & birth that you would like to discuss with us. Your HOME BIRTH PLAN is very important to us! We encourage you to prepare a written HOSPITAL BIRTH PLAN in the event of a transfer. Give a copy of your HOSPITAL BIRTH PLAN to your Dr and put a copy in your hospital transfer bag.

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES: Are you ALLERGIC to anything? ☐ NO. ☑ Yes, explain

☐ Drugs _____
_____
_____
☐ Foods _____
☐ Insect stings _____
☐ Betadine / Iodine _____
☐ Latex _____
☐ Other _____

PRESENT PREGNANCY INFORMATION:

Last Known Menstral Period (LKMP - 1st day) _____ - _____ - _____
Was your LKMP (above) normal? ☐ YES ☐ NO, explain: _____
Suspected Date of Conception (DOC) _____ - _____ - ____
Did a Pregnancy test? ☐ NO ☐ YES, when? _____ - _____ - _____
Was this a PLANNED pregnancy? ☐ YES ☐ NO
Most recent contraception used: _____
What are your feelings about this pregnancy? _____
How does your partner/husband feel? _____
Why are you considering a home birth? _____
_____
_____
Do you plan to BREASTFEED? ☐ YES ☐ NO, explain why not: ___
_____
Does your partner/husband support you? ☐ YES ☐ NO, explain:

CURRENT PREGNANCY PROBLEMS: ☑ Yes, give details & when:

☐ Nausea _____
☐ Vomiting _____
☐ Cold/Flu/Other? _____
_____
☐ Infections _____
☐ Fever (what °F?) _____
☐ Headache(s) _____
☐ Dizziness _____
☐ Indigestion (heartburn) _____
☐ Leg cramps _____
☐ Rash(es) _____
☐ Backache _____
☐ Swelling (edema) _____
☐ Constipation _____
☐ Diarrhea _____
☐ Urinary complaints _____
☐ Urinary infection (UTI) _____
☐ Abdmnl/pelvic pain _____
☐ Vaginal bleeding/spotting ___
_____
☐ Vaginal discharge _____
☐ Vaginal infection(s) _____
☐ Bleeding gums _____
☐ Dental problems _____
☐ Varicose veins _____
☐ Hemorrhoids _____
☐ Depression/Loneliness _____
☐ Family/Relation/Work problems:
_____
☐ Other _____

CURRENT PREGNANCY EXPOSURES: ☑ Yes, explain details & when?

☐ Smoke/chew Tobacco _____
☐ 2nd-hand smoke _____
☐ Caffeine _____
☐ Alcohol _____
☐ Marijuana _____
☐ Cocaine / Crack _____
☐ Other street drugs _____
☐ Rx medications _____
☐ O.T.C. medications _____
☐ Vitamins / minerals _____
☐ Herbs _____
☐ Homeopathics _____
☐ Other supplements _____
☐ New/strange animal(s) _____
☐ Cat box litter _____
☐ Fumes / sprays _____
☐ Chemicals _____
☐ Paint / solvents _____
☐ X-Rays (incl. dental) _____
☐ Ultrasound _____
☐ CAT scan / MRI _____
☐ Measles / Viruses _____
☐ Vaccinations _____
☐ Travel (where?) _____
☐ Other toxic exposure/concerns:
_____

Please use the space below to add any other information, health history, details, or notes regarding this CLIENT REGISTRATION & HEALTH HISTORY form. Also, include any pertinent or important financial / insurance information here. Feel free to discuss your FINANCIAL PLAN with us! We are happy to help you work out an affordable, flexible, and timely payment plan that fits your budget!

_____
_____
_____
_____
_____
_____
_____
_____

© 2010 HBMS ~ VA