YOUR NAME______________________________
SOCIAL SECURITY NUMBER:_______-________-_______________
LEGAL MARITAL STATUS:______________________________
RACE/ETHNICITY:______________________________
EDUCATION LEVEL:
OCCUPATION:
PREFERRED LANGUAGE:_____________ RELIGION:____________
HOW LONG HAVE YOU BEEN WITH THIS PARTNER? ____________
IS THIS PREGNANCY WANTED? ______________________

MAIDEN LAST NAME______________________________
BABY SEX & NAME: ______________________________
WHO DO YOU LIVE WITH? ______________________________
DESCRIBE YOUR SOCIAL SUPPORT SYSTEM: ________________
EMERGENCY CONTACT (BESIDES PARTNER): ________________
EMERGENCY CONTACT U.S. PHONE #: ______________________
EMERGENCY CONTACT RELATIONSHIP:______________________

LIST ALL PAST PREGNANCIES BELOW
HOW MANY LIVING CHILDREN DO YOU HAVE: ______ HOW MANY MISCARRIAGES: ______ HOW MANY ABORTIONS: ______ ECTOPIC: ______

DATE THE PREGNANCY ENDED MM/DD/YY	GESTATIONAL WEEKS	HOURS OF ACTIVE LABOR	WEIGHT	SEX&NAME (if applicable)	DELIVERY TYPE (Miscarriage, abortion, vaginal, forceps, vacuum, cesarean)	WHICH PAIN MEDS USED	LOCATION (Home, or specific hospital or birth center)	BREASTFEEDING (How long, difficulties?)	COMPLICATIONS OF PREGNANCY, BIRTH, POSTPARTUM (Gestational diabetes, pre-eclampsia, blood pressure, induction, shoulder dystocia, stitches, cholestasis, postpartum depression, postpartum hemorrhage, etc.)

MEDICAL & SOCIAL HISTORY	NO | YES	IF YES, GIVE DETAILS BELOW
DIABETES / PRE-DIABETES	☐ | ☐	***********************************
CARDIOVASCULAR DISEASE / HIGH BLOOD PRESSURE / HEART DISEASE	☐ | ☐	
BLOOD CLOT OR DEEP VEIN THROMBOSIS OR BLOOD VESSEL INFECTION	☐ | ☐	
AUTOIMMUNE DISORDER	☐ | ☐	
KIDNEY DISEASE / INFECTION OR FREQUENT UTIs	☐ | ☐	
NEUROLOGIC ISSUES / EPILEPSY	☐ | ☐	
PSYCHOLOGICAL: DEPRESSION / ANXIETY / POSTPARTUM / OTHER	☐ | ☐	
METABOLIC DISORDER: EX: MTHFR, G6PD, ETC	☐ | ☐	
HEPATITIS / LIVER DISEASE	☐ | ☐	
CLOTTING DISORDER	☐ | ☐	
THYROID ISSUE / ENDOCRINE DISORDER	☐ | ☐	
TRAUMA/VIOLENCE/SEXUAL ABUSE	☐ | ☐	
HISTORY OF BLOOD TRANSFUSION	☐ | ☐	

SUBSTANCE USE	PRE-PREG QUANTITY	PREGNANCY QUANTITY	YEARS USED
ALCOHOL			
TOBACCO			
CANNABIS			
OTHER DRUGS			

....	NO | YES	IF YES, GIVE DETAILS BELOW
D (RH) SENSITIZED (For Rh neg women only)	☐ | ☐	***************************************
LUNG PROBLEMS (TUBERCULOSIS, ASTHMA, ETC)	☐ | ☐	
MUSCULOSKELETAL / RESIDUAL INJURIES	☐ | ☐	
GASTROINTESTINAL (CROHN'S, IBD, ETC)	☐ | ☐	
OPERATIONS / HOSPITALIZATIONS	☐ | ☐	
ANESTHESIA COMPLICATIONS	☐ | ☐	
ABNORMALITY OF THE UTERUS (FIBROIDS, ETC.)	☐ | ☐	
GYNECOLOGIC PROCEDURES (UTERINE SURGERY, LEEP, CONE BIOPSY, ETC)	☐ | ☐	
PAST ABNORMAL PAP SMEAR	☐ | ☐	
INFERTILITY or PCOS	☐ | ☐	
BREAST ABNORMALITY	☐ | ☐	
INACTIVE LIFESTYLE	☐ | ☐	
FAMILY HISTORY: FIRST DEGREE RELATIVE (parent, sibling, child) W/ - DIABETES TYPE II - THYROID DISEASE - CLOTTING DISORDER - BREAST / OVARIAN CANCER - PRE-ECLAMPSIA or HELLP	☐ | ☐	
27. OTHER MEDICAL OR SOCIAL CONDITIONS (SELF) NOT LISTED	☐ | ☐	

INFECTION HISTORY	NO	YES	**IN PAST 6 MONTHS...**	NO	YES
1. LIVE WITH SOMEONE WITH TUBERCULOSIS OR EXPOSED TO TUBERCULOSIS	☐	☐	6. MORE THAN ONE SEX PARTNER	☐	☐
2. HAVE HAD A SEXUALLY TRANSMITTED DISEASE NOW OR IN THE PAST	☐	☐	7. SYMPTOMS OF OR TREATMENT OF AN STI	☐	☐
3. I OR MY CURRENT PARTNER(S) HAS GENITAL HERPES	☐	☐	8. INJECTION DRUG USE	☐	☐
4. TRAVELED OR PARTNER TRAVELED TO ZIKA AFFECTED AREAS WITHIN THE LAST 6 MONTHS BEFORE CONCEPTION	☐	☐	9. I HAVE HAD A HEPATITIS B POSITIVE SEX PARTNER	☐	☐
5. OTHER INFECTION AFFECTING PREGNANCY (LIST IN COMMENTS)	☐	☐			

IF YES, GIVE DETAILS:

YOUR NAME: ____________

GENETICS & BIRTH DEFECT SCREENING - FAMLY HISTORIES (SELF, FATHER OF BABY, OR ANYONE IN EITHER FAMILY)

	NO	YES		NO	YES
CYSTIC FIBROSIS	☐	☐	MY AGE WILL BE 35 OR MORE AT MY ESTIMATED DUE DATE	☐	☐
TAY-SACHS (EG. JEWISH, CAJUN, FRENCH-CANADIAN)	☐	☐	THIS PREGNANCY IS KNOWN OR SUSPECTED TWINS / MULTIPLES	☐	☐
HUNTINGTON'S CHOREA	☐	☐	I MAY HAVE TAKEN HARMFUL MEDICATIONS / SUPPLEMENTS / HERBS / DRUGS / ALCOHOL SINCE MY LAST PERIOD	☐	☐
CONGENITAL HEART DEFECT	☐	☐	I MYSELF HAVE A METABOLIC DISORDER (E.G. TYPE 1 DIABETES, PKU)	☐	☐
MUSCULAR DYSTROPHY / SPINAL MUSCULAR ATROPHY	☐	☐	I HAVE HAD 3 OR MORE MISCARRIAGES / 1 OR MORE STILLBIRTH	☐	☐
CANAVAN DISEASE	☐	☐	IF YES TO ANY ABOVE, GIVE DETAILS HERE:		
BLOOD DISORDERS SUCH AS THALASSEMIA / HEMOPHILIA / SICKLE CELL OR TRAIT / OTHER BLOOD DISORDER	☐	☐			
NEUTRAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, ANENCEPHALY)	☐	☐			
MENTAL RETARDATION / DOWNS SYNDROME / FRAGILE X	☐	☐	ARE YOU INTERESTED IN TESTING FOR GENETIC & NON-GENETIC		
OTHER BIRTH DEFECTS, GENETIC, HERITABLE, or CHROMOSOMAL DISORDERS	☐	☐	CONGENITAL DISORDERS FOR THIS PREGNANCY? ☐ YES ☐ NO		

PHYSICAL & SYMPTOMS

HEIGHT______ YOUR WEIGHT BEFORE YOU BECAME PREGNANT? __________pounds. HOW MANY TATTOOS DO YOU HAVE? _______
HAVE YOU EXPERIENCED A RASH SINCE PREGNANCY? (If yes, describe) ____________
HAVE YOU EXPERIENCED ANY PREGNANCY WARNING SIGNS (LISTED ON PAGE 3 OF YOUR BIRTH PASSPORT)? ____________

BREASTS: ANY HARD LUMP? ☐ Yes ☐ No PLACES WHERE SKIN PULLS IN? ☐ Yes ☐ No COLORED DISCHARGE? ☐ Yes ☐ No

BREAST SKIN CHANGED TO RED & DRY? ☐ Yes ☐ No NIPPLE TYPE: ☐ EVERTED (sticks out) / ☐ FLAT / ☐ INVERTED

DATING & ULTRASOUNDS

WHAT "DUE DATE" WERE YOU GIVEN? _____/______/________ BASED ON: ☐ Last Menstrual Period ☐ 1st trimester ultrasound ☐ Other: ______________

DATE OF THE FIRST DAY OF YOUR LAST PERIOD: ________________ IS THIS AN EXACT RECORDED DATE OR APPROXIMATE DATE? ☐ EXACT ☐ APPROX
WHEN WAS YOUR 1ST POSITIVE PREGNANCY TEST? ______________ HOW OFTEN DO YOUR PERIODS COME? (e.g., 28, 30, 27-35, 20-40, etc)? __________ days

WAS YOUR LATEST PERIOD A NORMAL PERIOD (Usual amount and duration): ☐ Normal ☐ Unusual (In what way? ________________)

WERE YOU USING HORMONAL CONTRACEPTION (the pill / patch / ring / hormonal IUD) WITHIN 3 MONTHS OF CONCEPTION?: ☐ YES ☐ NO

WERE YOU BREASTFEEDING AT CONCEPTION? ☐ YES ☐ NO DO YOU KNOW THE EXACT DATE YOU CONCEIVED / OVULATED: ___________________
HAVE YOU HAD ANY ULTRASOUNDS OF THIS PREGNANCY? List at how many weeks of pregnancy: ____________

EMERGENCIES & ALLERGIES

IN AN EMERGENCY, DO YOU WANT EVERYTHING POSSIBLE DONE TO SAVE YOUR LIFE INCLUDING RESUSCITATION & BLOOD TRANSFUSION? ☐ Yes ☐ No
(If no, bring your advanced directive to scan into your chart and explain details here): ____________

DRUG ALLERGIES & REACTION: ____________________ LATEX ALLERGY: ☐ No ☐ Yes. SIGNIFICANT FOOD/ENVIRONMENTAL ALLERGY: ______________

COMPLICATIONS IN THIS PREGNANCY

Anemia:____________
Gestational diabetes:____________
Baby "too big/small":____________
UTI:____________
Placenta abnormalities:____________
Lab test abnormalities:____________
Abnormalities on ultrasound:____________
Vaginal Bleeding:____________
Other:____________
Other:____________

LIST ALL MEDICATIONS, SUPPLEMENTS, HERBS USED THIS PREGNANCY

Prenatal Vitamins:____________
Omega 3s / DHA:____________
Probiotics for Women's Health:____________
Additional supplements:____________
Herbs or homeopathic medicines:____________
Vaccines this pregnancy (circle): Tdap(whooping cough) / Flu shot / Hepatitis B
Antibiotics or antifungal (yeast cream, etc):____________
Rho-gam (for Blood type Rh negative women):____________
Alcohol / other drugs:____________
Other:____________

LABS

DO YOU KNOW YOUR BLOOD TYPE: ______________
WHEN WAS YOUR LAST PAP SMEAR (month & year): ________________ Result: ________________

EDUCATIONAL TOPICS CHECK ONE BOX:	YES / I UNDERSTAND	NO / I HAVE QUESTIONS
I have received a birth orientation tour or was a previous client here.		
My prenatal visits start out every 3-6 weeks in the 1st trimester and become more frequent until they are every week at term. Visits rotate between midwives so we can get to know each other.		
I have reviewed the Best Start Birth Center Birth Passport booklet that I received, I know how and when to call the midwife urgently.		
Foods to avoid: shark, tilefish, swordfish, king mackerel, contaminated deli meat, unpasteurized dairy, pate, unwashed vegetables, raw or undercooked animal products.		
Toxoplasmosis Prevention: I should not eat raw meats and should not empty cat litter boxes.		
Mild / moderate exercise is safe unless I have a special condition. We recommend 30 mins daily.		
Sex in pregnancy is safe unless it is painful or I have a special condition.		
If cleaning with chemicals, I should wear gloves and a mask. If my job involves working around radiation, I will speak with my employer and take safety precautions in pregnancy.		
Plane travel is safe if I prevent blood clots by moving/standing frequently. Avoid tropical disease.		
Before taking medications, supplements, or herbs, I will ask my midwife.		
Tobacco, alcohol, marijuana, and other drugs should be avoided, including high dose caffeine.		
Medically needed ultrasounds such as the 20-week anatomy scan, etc. are coordinated by Best Start. Elective and 4D ultrasounds should be avoided due to lack of safety data.		
If I have concerns about domestic violence, I will contact my midwife ASAP.		