Skaidre Brown, Licensed Midwife, PLLC
Phone: (360)421-5140 Fax: 1(888)728-0157

CLIENT REGISTRATION

Name	First	Middle		Last	Maiden?	Date	Phone (home) (work)	
Race	Religion	Yrs Educ	Marital Status	Occupation/Type of Business		Date of Birth	State of Birth	
Address:	Street			City	Zip	Inside City Limits? ☐ Yes ☐ No	How long at this address?	
Partner/Spouse: First		Middle	Last	Race	Yrs. Educ	Date of Birth	State of Birth	
Address (if different from above)						Phone (work) (Home)	Occupation/type of business	
Is your partner the biological parent of this baby:			Another person to contact in emergency: Name:			Phone Relationship		
Method of Payment: ☐ Medicaid	☐ Other : ☐ Cash		Insurance Information: Copay Policy #			Name of Policy Holder: Group #		
Social Security Number:	Partner's SNN:		SNN Requested for baby: ☐ Yes ☐ No			Referred by:		

Please answer the following questions which will help determine if there are potential problems which should be discussed further. This information is completely confidential.

Family History – *Indicate if anyone in your immediate family has ever had any of these, who; when.*

- ☐ High Blood Pressure _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Twins _____
- ☐ Severe emotional problems _____
- ☐ Alcohol/drug abuse _____
- ☐ Other _____

Second Biological Parent – *Indicate if they have ever had any of these; when.*

- ☐ Sexually transmitted diseases _____
- ☐ Herpes: ☐ Genital ☐ Oral
- ☐ Severe emotional problems _____
- ☐ Alcohol/drug abuse _____
- ☐ Tobacco use _____
- ☐ Other _____

Your Mother's History – *Please answer the following regarding your mother:*

- ☐ No. of pregnancies _____
- ☐ No. of births _____
- ☐ Miscarriages _____
- ☐ Any complications _____
- ☐ Your weight at birth _____

PREVIOUS PREGNANCY OUTCOMES Please complete this table regarding your own pregnancies (from earliest to most recent)

Date	#Weeks	Birth/Miscarriage/Termination	Comments/Problems

Yes No Have you or the second biological parent ever had a baby with a birth defect or mental or physical development delay?

Yes No Do you or the second biological parent have any family members with birth defects or conditions diagnosed as genetic or inherited?

Yes No Are you and the second biological parent related by blood? (e.g., cousins)

Yes No Are you or the second biological parent from any of these ethnic/racial groups? (circle)

Jewish Black/African Asian Mediterranean

Yes No Have you or the second biological parent ever had hepatitis or jaundice?

Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?

Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?

Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

Yes No Do you think you are at increased risk for AIDS/HIV?

Yes No Have you ever experienced dramatic fluctuations in your weight?

Yes No Have you ever had anorexia, bulimia or any other disordered eating problem?

Yes No Is there anything about the development of your sexuality that you'd like to discuss?

Yes No Have you ever been in an abusive relationship, including now, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?

Yes No Have you ever had severe emotional problems?

Yes No Have you ever been on any medication for psychological problems?

Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

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CLIENT REGISTRATION 2

MEDICAL HISTORY

Please indicate if you have ever had any of these; when:

- ☐ Severe headaches _____
- ☐ Eye/vision problems _____
- ☐ Ear/hearing problems _____
- ☐ Dental problems _____
- ☐ Thyroid problems _____
- ☐ Rheumatic fever _____
- ☐ Blood clotting problems _____
- ☐ Anemia _____
- ☐ Hemorrhage _____
- ☐ High blood pressure _____
- ☐ Varicose veins _____
- ☐ Hemorrhoids _____
- ☐ Tuberculosis _____
- ☐ Asthma _____
- ☐ Skin disorders _____
- ☐ Ulcers _____
- ☐ Other _____

- ☐ Bowel problems/colitis _____
- ☐ Blood in stool _____
- ☐ Gall bladder problems _____
- ☐ Liver problems _____
- ☐ Hepatitis _____
- ☐ Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Bladder infection _____
- ☐ Kidney infection _____
- ☐ Urinary surgery _____
- ☐ Urethral dilation _____
- ☐ Aching joints _____
- ☐ Pelvic/back injuries _____
- ☐ Seizures _____
- ☐ Cancer _____
- ☐ Hospitalizations _____
- ☐ Surgeries
- ☐ Other _____

Do you have any allergies? ☐ Yes ☐ No _____

GYNECOLOGIC HISTORY

Age at first period _____
Cycle length (days) _____
Regular? ☐ Yes ☐ No
Duration _____

When was your last Pap smear? _____
Have you ever had an abnormal Pap? (dates) _____
Please describe _____

Please indicate if you have ever had any of the following; when:

- ☐ Yeast _____
- ☐ Trichomonas _____
- ☐ Group B Strep _____
- ☐ Bacterial vaginosis _____
- ☐ Chlamydia _____
- ☐ Gonorrhea _____
- ☐ Syphilis _____
- ☐ PID/Pelvic infection _____
- ☐ Genital Sores _____
- ☐ Herpes:
  - ☐ Genital ☐ Oral
- ☐ Condyloma (warts) _____

- ☐ Cervicitis _____
- ☐ Cervical surgery _____
- ☐ Cervical polyp _____
- ☐ Ovarian cyst _____
- ☐ Fibroids _____
- ☐ Endometriosis _____
- ☐ Abnormal bleeding _____
- ☐ Uterine surgery _____
- ☐ Breast lump(s) _____
- ☐ Breast surgery _____
- ☐ Infertility _____
- ☐ Other _____

Are there any particular ethnic, cultural or religious preferences for your care during pregnancy and birth that you'd like to discuss?

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? ☐ Yes ☐ No
Suspected date of conception _____
Pregnancy test (date) _____

Planned pregnancy? ☐ Yes ☐ No
Feelings about pregnancy _____
Partner's feelings _____
Most recent birth control used _____
Contraception used in past; what, when, any problems? _____

Please indicate if you've had any of the following problems during this pregnancy.

- ☐ Nausea _____
- ☐ Vomiting _____
- ☐ Fever _____
- ☐ Infections _____
- ☐ Headache _____
- ☐ Dizziness _____
- ☐ Indigestion _____
- ☐ Leg cramps _____
- ☐ Rash _____
- ☐ Backache _____
- ☐ Swelling _____
- ☐ Constipation _____
- ☐ Diarrhea _____

- ☐ Urinary complaints _____
- ☐ Abdominal/pelvic pain _____
- ☐ Vaginal bleeding/spotting _____
- ☐ Vaginal discharge _____
- ☐ Bleeding gums _____
- ☐ Varicose veins _____
- ☐ Hemorrhoids _____
- ☐ Depression _____
- ☐ Loneliness _____
- ☐ Family/relationship problems
- ☐ Work problems _____
- ☐ Other _____

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

- ☐ Tobacco _____
- ☐ Alcohol _____
- ☐ Caffeine _____
- ☐ Marijuana _____
- ☐ Cocaine _____
- ☐ Street drugs _____
- ☐ Other meds _____
- ☐ Non-pres. drugs _____
- ☐ Vitamins _____

- ☐ Herbs _____
- ☐ Fumes/sprays _____
- ☐ X-rays _____
- ☐ Ultrasound _____
- ☐ Measles/Viruses _____
- ☐ Travel _____
- ☐ Vaccinations _____
- ☐ Cats _____
- ☐ Other _____

Planned place of birth:

☐ Home ☐ Birth Center ☐ Hospital

If home, please indicate if you have:

☐ Water ☐ Electricity ☐ Telephone

Please use this space to add any other information regarding any of the above: