MIDWIFERY INTAKE FORM

Client's Name			Partner's Name		
Street Address (incl. City & Postal Code)					
CareCard# / PHN#	Home Phone	Cell Phone	Work Phone	Partner Cell Phone	Partner Work Phone
Date of Birth m/d/y	Age	Occupation	Partner Date of Birth	Partner Age	Partner Occupation
Email Address for appointment reminders:					

Directions to home:

Intended Place of Birth		Physician	Phone
LMP	EDD	Allergies	

Obstetrical History (include all pregnancies)

Date	Place of Birth	Weeks at delivery	Hours in labour	Delivery type	Comments	Sex	Weight	Present health

Method of contraception	Date contraception discontinued	Last normal period
Conception date (if known)?	Pregnancy test (date/result)	When first felt movement (16-20 weeks)?

Have you experienced any of the following during this pregnancy?

	No	Yes		No	Yes		No	Yes
Fainting			Blurred Vision			Diarrhea		
Anemia			Rubella			Constipation		
Fatigue			Spotting			High blood pressure		
Morning sickness			Infection			Varicose veins		
Comments								

Have you experienced any of the following during this pregnancy?

	No	Yes	Amount		No	Yes	Amount		No	Yes	Amount
Coffee				OTC drugs				Alcohol			
Cigarettes				Prescription drugs							

Diet

Vegetarian		Supplements/Medications (List)
Other Special Diet		
Folic Acid Start Date		

Lifestyle Information

Plans for working during this pregnancy?	Plans for working following birth?
Exercise program?	Sleeping pattern
Complementary Treatments (naturopathy, chiropractic, massage therapist, etc.)	

Client's Mother's Obstetrical History

Pregnancies	Births	Miscarriages	Stillbirths	Vaginal births
C-Sections	Forceps	Breech	Twins	Length of labour
Breast-fed?		Client's birth		

During previous pregnancies did you have any of the following:

	No	Yes		No	Yes		No	Yes
Anemia			Spotting/Bleeding			High Blood pressure		
Constipation			Hemorrhage			Morning Sickness		
Edema			Bladder / Kidney problems			Premature Rupture of Membranes		
Leg cramps			Dizziness / fainting			Wt gain > 35 lbs or <20 lbs		
Pre_eclampsia			Hospitalizations			Postpartum depression		
Varicose veins			Prematurity			Induced labour		
Episiotomy			Tearing			Difficulty with placenta		
Anesthesia			Forceps			Depression after birth		
Comments								

Medical History - Past Illnesses

	No	Yes		No	Yes		No	Yes
Anemia			Epilepsy			Blood Transfusion		
Anorexia			Heart Disease			Chicken Pox		
Arthritis			Hypoglycemia			Thyroid problems		
Asthma			Pelvic fractures/breaks			Digestive problems		
Blood Disorders			Infections			Urinary tract infections		
Cancer			Depression/Psychiatric Illness			Varicose veins		
Diabetes			Surgery/hospitalization			Sexual Abuse		
Accidents/Injuries			Reaction to anaesthetic					
Comments								

Family History

	No	Yes		No	Yes		No	Yes
Alcoholism/drug abuse			Blood disorders(clotting)			Multiple births		
Cancer(breast or cervix)			Diabetes(age discovered)			Inherited/Ethnic diseases		
Heart Disease			Severe allergies			High blood pressure		
Depression or Psychiatric illness								
Comments								

Please add any comments, thoughts, fears or areas you would like discussed:
