Lincoln OB-GYN, P.C. Midwife History Form

Name: _____ Date: _____

Your appointment is scheduled with (please circle):

Carol Greenlee, C.N.M Jill Dolberg, C.N.M. Mary Dickerson, C.N.M.

Reason for today's visit? _____

Review of Systems:

If you have noticed any of these recently, please circle

Fatigue/ night sweats /weakness /fainting/ menopause symptoms
Impaired vision / blurred vision
Headaches / light headedness
Breast lumps / pain / nipple discharge
Chest Pain/ palpitations/ Shortness of breath/ wheezing/ chronic cough
Nausea/vomiting/ diarrhea/ constipation/ blood in stools
Pain with Urination/ incontinence/ vaginal discharge/ irregular vaginal bleeding/ vaginal itching/ pelvic pain
Weight loss/ thyroid problems/ Swelling in hands/ swelling in ankles/ swelling in feet
Difficulty sleeping/ Depression / emotional stressors

Obstetrical History:

Please include miscarriages and abortions. ** NO CHANGES _____

Year	Sex	Baby's Weight	Term or Premature	Vaginal or Cesarean	Miscarriage or Abortion	Place	Doctor	Baby Name	Complications
1.									
2.									
3.									
4.									
5.									
6.									

Previous Surgical/Trauma History:

Please include any surgery or trauma such as broken bones, concussions or injuries that you have had in the past. ** NO CHANGES _____

Year	Type of Surgery/Trauma	Place	Doctor	Complications
1.				
2.				
3.				
4.				
5.				
6.				

Past Medical History: In the past have you had any of the following please circle

Frequent or severe headaches
Dizziness
Stroke
High blood pressure
Thyroid/glandular problems
Asthma, bronchitis, pneumonia
Epilepsy
Diabetes
Cancer
Anemia
Chickenpox, measles, or mumps
MRSA
Mental disease/ Nervous conditions/ Depression/ Anxiety
Breast disease
Gallbladder disease
Phlebitis/varicose veins
Eating disorders or significant weight loss
Infection of female organs
Ovarian cysts/ Endometriosis/ Fibroids
Kidney/bladder infection
German measles
Hepatitis, mono, recent jaundice, or liver disease
High cholesterol
Have you ever been raped or abused
Infertility

Did any of them require hospitalization? YES or NO

Are your vaccinations current (rubella, tetanus, etc.)? YES or NO

Contraceptive History:

Current type used (male or female):_____ If birth control pills, what kind and dosage:_____

Gynecologic History:

Menstrual age onset: _____ Length of time between periods from day 1 to day 1: _____

How many days you flow? _____ When was your last period? _____ Do you have cramps? _____

Do you have painful periods or PMS? _____ Is it Heavy, Moderate or Light? _____

Date of last Pap? _____ History of abnormal pap and if so, when? _____

Age when sexually active? _____ Total number of partners? _____ Date of last mammogram? _____

History of venereal disease such as warts, gonorrhea, Chlamydia, herpes?_____

Did your mother take hormones/DES while carrying you? _____

Family History: Circle and indicate which family member.

High blood pressure
Stroke
Heart disease
Multiple Births
Birth defects (including mental retardation or Down's Syndrome)
Bleeding Disorders
Breast Disease
Kidney disease
Bleeding disorders
Anemia
Epilepsy
Thyroid Problems
Diabetes
Mental disease
Cancer

Medication History:

List any Drug Allergies: _____

Current Medications and dosages: _____

Social History:

Do you use the following? If so, how much:

Cigarettes_____ Alcohol _____Drugs_____Caffeine _____

Are you undergoing excessive stressors? _____

Do you feel safe at home? _____

Preventative Health Care:

How is your nutrition? _____ What is your calcium intake? _____

Do you exercise? How often? What type? _____

Do you wear your seat belt? _____ When was your last dental checkup? _____

Do you do breast self-exams (how often)?_____

Do you wear glasses? _____ or contacts? _____ NO _____

Are you undergoing excessive stress? _____

Partner Information: ** NO CHANGES _____

Name: _____ Age: _____

Height: _____ Weight: _____ Education: _____ Occupation: _____

Obstetrical History:

Did you have any of the following problems with any pregnancy?

_____ high blood pressure _____ Diabetes _____ preterm labor _____ hemorrhage

_____ depression or postpartum blues. Other _____

Did the baby have any problems after birth?

_____ jaundice , _____ heart problem, _____ breathing problem , _____ feeding problems,
_____ birth defects. Other _____

Did you have any multiple births (twins, triplets, etc)? _____

Are all your children now alive? _____

Any concerns or comments about previous births_____

_____

_____

If you are currently pregnant please continue:

Weight at last menstrual period? _____ Date of positive pregnancy test? _____

Do you have cats? _____Any exposure to radiation or other dangerous substances? _____

Drug/alcohol abuse? _____ Significant health problems?_____

Family medical history (sickle cell anemia, Tay Sachs,, child with abnormality, or any family hereditary disease?) _____

Check all symptoms that you have had since your last period:

_____ nausea _____ vomiting _____ indigestion _____ constipation _____ headache
_____ bleeding _____ vaginal discharge _____ edema (swelling) _____ abdominal pain
_____ urinary complaints _____ German measles _____ other viruses

Stressors:

_____ unplanned pregnancy
_____ newly married/separated
_____ emotional stress
_____ job or residence change
_____ unsupportive family member
_____ physical violence in the home

Thank-you for taking the time to fill out this questionnaire.

Please add anything else we should know about your needs.