

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

Name: _____

Date: _____

Your appointment is scheduled with (please circle):

Jill E. Dolberg, C.N.M.

Dana R. Rhodes, C.N.M.

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

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 | Kidney disease |
| Stroke | Bleeding disorders |
| Heart disease | Anemia |
| Multiple Births | Epilepsy |
| Birth defects (including mental retardation or Down's Syndrome) | Thyroid Problems |
| Bleeding Disorders | Diabetes |
| Breast Disease | 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 _____ job or residence change
_____ newly married/separated _____ unsupportive family member
_____ emotional stress _____ 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.***