

Pregnancy History

Name: _____

Estimated due date: _____

Delivering Practitioner: Midwives OB/Gyn Name: _____

Choice of birth place: Home Birthing Center Hospital: _____

Is this your first pregnancy? Yes No Did you have fertility treatments? Yes No

Have you experienced any traumas during this pregnancy? (accidents, falls) _____

Have you had any evaluation procedures (Ultrasound, amniocentesis, chorionic villus sampling) Please list frequency & reasons: _____

Is this pregnancy being treated as high-risk? Yes No If so, why? _____

Have there been any stressful events in your life during this pregnancy? _____

Previous Birth History

How many other births have you had? ____ Were fertility methods used? Yes No

At what week of pregnancy were your previous babies born? _____

Previous care givers: Midwives OB/Gyn Doula

Place of birth: Home Birthing Center Hospital

Please circle all that pertain to your previous births: *vaginal delivery c-section epidural induction forceps vacuum breech baby presentation back labour*
Other: _____

Previous birthing positions: *Lithotomy (on back with feet up) Squatting On all fours Side-lying Birth stool Birthing water tub* Other: _____

Infant History

Please circle if your babies experienced any of the following:
Premature birth Neonatal ICU Low APGAR scores Low birth weight Failure to thrive Colic Breathing difficulties Allergies Breastfeeding difficulties Formula-fed Developmental delays Other: _____