Please complete this patient information survey to the best of your knowledge & ability. Please leave any sections blank if you are unsure or uncomfortable answering. The purpose of these questions is to recognize a holistic range of factors which may affect your care, and to help us identify and meet your individual health needs. This survey will become part of your confidential medical record. Thank you!

Name: _____ **Date of Birth (M/D/Y)**: _____ **Age**: _____

I. PERSONAL INFORMATION:

What is your relationship status (single, married, divorced, partnered, etc.)?
_____

Occupation (job, student, stay-at-home mom, etc.)?
_____

Living Situation: who shares your home (roommates, husband & kids, dogs/cats, etc.)?

_____

II. CURRENT PREGNANCY:

1st day of last menstrual period (if known): _____ Are you certain of this date? **Yes / No**

Length of Menstrual Cycles: Every _____ Days
(measured from 1st day of one period to 1st day of next period; i.e. every 28 days, or 21-38 days if irregular)

Were you on birth control or breastfeeding at the time of conception? **Yes / No**

Have you had any ultrasound during this pregnancy? **Yes / No**

Was this pregnancy planned? **Yes / No**

If pregnancy was unplanned, are you considering termination or adoption? **Yes / No**

Please note if this pregnancy was conceived with fertility treatment (i.e. Clomid, IVF), donor eggs or sperm, or if you are a surrogate or gestational carrier:

_____

Name of Father of Baby & Relationship to You:

_____

Do you or the baby's father have any personal history or blood relatives with the following conditions:
(Please check if applicable)

____ Cleft lip/palate	____ Autism	____ Developmental Delays
____ Cystic Fibrosis	____ Hemophilia	____ Chromosome Disorders
____ Congenital Heart Defect	____ Deafness	____ Stillbirth
____ Muscular Dystrophy	____ Thalassemia	____ Huntington's
____ Neural Tube Defect (spina bifida)	____ Sickle cell	____ Other known genetic disease
____ Tay-Sachs or Ashkenazi Jewish ancestry		

III. MEDICAL HISTORY:

Have you had your COVID vaccination? **Yes / No** If you have not would you be interested in getting it? **Yes / No / Maybe**

Please list any **allergies** below (latex, medications, foods, etc.):

Please list all current **prescription medications**, as well as any **vitamins/ supplements** you use on a regular basis.
Approximate date and location (please specify name of medical office / facility) of your **last Pap**?
(Please write "N/A" if you've never had a pap)

Please list any **surgeries** you've had & approximate year of procedure:

Have you had any hospital admissions other than for surgeries listed above, or childbirth? **Yes / No**

Please complete table below: Are **you or your blood relatives** (parents, grandparents, siblings, children, aunts/uncles) affected by any of the following conditions? If so, please check the appropriate column, indicate age at onset of the condition (approximate is fine), and note which relative was affected or any additional details.

☐ Please check here if you are adopted

	Me	Family	Age at Onset	Notes
Thyroid Disease (i.e. Hashimoto, Graves)				
Hypertension (high blood pressure)				
Diabetes (including gestational diabetes)				
Preeclampsia				
Mental Illness (including depression, anxiety, eating disorder, postpartum depression, PTSD)				
Blood Clot (DVT, PE)				
Seizures				
Preterm Delivery (<37 wk)				
Twin or multiple pregnancy				
Autoimmune Disease (i.e. lupus, MS, RA)				
Kidney Disease				
Liver Disease (including hepatitis)				
Heart Disease (i.e. heart attacks, bypass surgeries, arrhythmia)				
Stroke				
Thrombophilia (i.e. Factor V Leiden)				
Cancer				

Please indicate Yes or No if **YOU** have/ have had the following:

	Yes	No		Yes	No
Asthma			Migraines		
Eczema or Psoriasis			GI disease: GERD, IBS, pancreatitis, or IBD (Crohns, colitis)		
Blood Transfusion			Chronic Pain or Fibromyalgia		
Kidney stones			Gallbladder stones or disease		
Fibroids			PCOS		
HPV Vaccine			Recurrent (>2 infections per year) : UTI, Yeast, or BV		
Genital Herpes			Other STI (chlamydia, gonorrhea, trich, HIV, syphilis) or PID		
Abnormal Pap			If Y, did you have colposcopy, cryotherapy, LEEP, or conization?		
Chickenpox			If N, have you had a varicella vaccine?		

Other Medical Issues? Notes on entries above?

_____

_____

Did you have this year's seasonal flu vaccine? **Yes / No**

Would you accept a blood transfusion if it was necessary? **Yes / No**

Please note any dietary restrictions (i.e. vegetarian, vegan, gluten-free, Kosher, etc.)

_____

IV. SOCIAL HISTORY

What was the highest grade or degree you completed in school?

_____

Do you currently, or have you ever, smoked cigarettes regularly? **Yes / No**

If Yes, what age did you begin smoking? _____

How much do you currently smoke? _____

If you quit smoking, when did you quit? _____

_____

Do you currently use marijuana? **Yes / No** __

Have you used alcohol or other drugs since becoming pregnant? **Yes / No** _____

Have you ever gotten help for a substance use disorder? (i.e. AA/NA program, opioid treatment, etc.)? **Yes / No**

Have you ever experienced domestic violence, sexual assault, or abuse? **Yes / No**

Do you currently feel safe in your home? **Yes / No**

If you have children, do you have full custody of your children? **Yes / No**

Do you belong to a religious community, tribe, or otherwise hold cultural / spiritual beliefs which might affect your care?
Please note Y / N and specify your community: **Yes / No**

_____

Please use the space below if you would like to note any additional information about your responses in this section.

_____

V. OBSTETRIC HISTORY

Have you had any miscarriages? **Yes / No**

_____

Have you ever terminated a pregnancy (had an abortion)? **Yes / No**

_____

Have you ever had an ectopic pregnancy? **Yes / No**
Have you ever had a molar pregnancy? **Yes / No**

_____ Please complete chart below for any births you've had:

Birth Date M/D/Y	Child's Name	Sex M / F	Gest Age/ # Weeks Pregnant	Labor Length (hours)	Delivery Type: Vag or C/S	Baby's Weight	Location of Birth If not at Mercy - Durango, note City, State; Home if home birth

Were forceps or vacuum used with your delivery? **Yes / No**

_____

Are all of your children currently living? **Yes / No**

_____

Do all of your children have the same father? **Yes / No**

_____

If you had a C-section: Do you know the indication (why it was done)? Please note in the space below.

Are you interested in a VBAC (vaginal birth after Cesarean)? **Yes / No**

_____

_____

Please note any complications you had with previous deliveries (i.e. postpartum hemorrhage, shoulder dystocia, 4th degree tear, placental abruption, etc.), or mark "N/A" if not applicable.

_____

_____

_____

VI. WELCOME!

✦ How did you hear about Southwest Midwives? (If you heard of us through a friend or relative, feel free to write their name!)

_____

✦ Is there anything else you would like us to know, or address with you at our first meeting?

_____

_____