

Medical & Personal History

Completed for Karin Hoskin

Please fill this out as completely as you can. I realize some of it is very personal and perhaps difficult. I need this information in order to serve you well. Please attach extra pages if you need to. Thank you for your honesty and trust. Be assured that all information on paperwork and discussed in appointments is held in the strictest of confidence.

Name _____ Age _____

Maiden name _____ Social security number _____
Date of birth _____ Birthplace (state or country) _____ Education _____

Phone _____ Email _____
Alternate Phone Numbers _____

Address _____
Anticipated address at time of birth if different _____ Inside city limits? _____

Partner's Name _____ Relationship Status _____
Date of birth _____ Birthplace (state or country) _____ Education _____

Medical History

Blood Type and Factor _____ Partner's Blood Type and Factor _____
Known Drug or Food Allergies:

Medications You Take Daily:

Please circle any of these conditions you have had, and elaborate below:

Hypertension	Asthma	Anemia
Low Blood Pressure	Epilepsy	Insomnia
Heart Disease	German Measles	Bleeding Problems
Lung Disease	Hepatitis	Severe Headaches
Kidney Disease	Skin Problems	Eating Disorders
Diabetes	Thyroid Problems	Phlebitis
Cancer	Severe Accident	Liver Problems
Depression	Substance Abuse	Poor Appetite
	Anything else?	

Do you know of any hereditary illnesses in your family or your partner's family that warrants telling me about? Is there a history of any of the above conditions?

How do you feel about your health in general? What type of practitioner do you see when unwell?

Do you have any cats?

Your Mother's History Regarding Pregnancy and Birth

How many times has your mother been pregnant? _____ Any twins? _____

Do you know of any miscarriages? _____

How many children now living? _____

Did your mother breastfeed any of her children and for how long? _____

Was she given DES while she was pregnant with you? _____

What are her attitudes surrounding childbirth?

What do you know about your birth?

Did she experience any complications with any of your siblings?

If you have sisters who have had children, what do you know about these experiences?

Your Reproductive History

Age your menses began _____

Is it different now than when it first started? _____

How many days do you bleed and what is the flow like? _____

How long is your cycle? _____ Is it regular? _____

When was your last Pap Smear? _____ Results? _____

Do you do a monthly breast exam? _____

How many times have you been pregnant? _____

How many children have you given birth to? _____

Please describe the history of your relationship with **birth control**. How old were you when you became sexually active? What birth control methods have you used? What methods work for you? Any problems?

Have you ever been a victim of a traumatic sexual experience?

If you have had any **abortions**, please list the date(s). Let me know how many weeks pregnant you were, and what type of abortion it was. How do you feel now about the experience?

If you have had any **miscarriages**, please list the date(s). Let me know how many weeks pregnant you were, what do you know about the possible causes, whether there were any complications, and anything else you feel is important.

*If you are Rh negative, did you receive RhoGam after these experiences?

Please circle any of these conditions you have experienced, and elaborate below:

PMS	Yeast Infection	Abnormal Pap Smear
Painful Menstruation	Painful Intercourse	Excessive Bleeding
Uterine Surgery	Difficulty Becoming Pregnant	Fibroid Cysts
Pelvic Inflammatory Disease	Recurring Urinary Tract Infections	Herpes
HIV Positive	Sexually Transmitted Disease	Vaginal Infection

This Pregnancy

Date of the first day of your last menstrual cycle: _____

Date of the previous cycle: _____

Do you know when you conceived? _____

Was this baby planned? Please elaborate:

Pre-pregnant weight: _____

Have you felt the baby move? _____ If so, when did you first feel it? _____

Do you smoke? _____ How many cigarettes per day? _____

Do you drink alcohol? _____ What type? _____

How often did you drink before you knew you were pregnant? _____

How many have you had since you have known you are pregnant? _____

Do you drink caffeinated beverages? _____ What type and how often? _____

Please list all prescription drugs you have taken during this pregnancy:

Please list all over-the-counter drugs you have taken during this pregnancy:

Please describe your relationship with recreational drugs, and let me know of any you have taken during this pregnancy:

Are you currently working outside of your home? If so, please describe your job:

What is your work plan after the birth?

Please circle any conditions you have experienced during this pregnancy and elaborate below:

Shortness of Breath	Leg or Muscle Cramps	Headaches
Constipation	Diarrhea	Dizziness
Visual Disturbances	Nausea or Vomiting	Hemorrhoids
Bleeding or Spotting	Abdominal Pain	Insomnia
Varicose Veins	Unusual Emotional Stress	Fainting
Swelling	Anything Else?	