Lydia Robinson, Birth Doula
www.laboredwithlove.com

MEDICAL AND PERSONAL HISTORY

PARENTS:

Mother

Name____DOB________Occupation________________

Address____

Phone (Cell)_________________________________(Other)______________________________________

Email Address____

Partner

Name____DOB________Occupation________________

Phone (Cell)_________________________________(Other)______________________________________

Email Address ____

PHYSICIAN/MIDWIFE & HOSPITAL:

Name ______________________________Practice/Group______________________ Phone___________

Hospital/Birth Center you plan to use_______________________________ Phone___________________

Pediatrician/Family Practice Physician__________________________________ Phone_______________

Date of First Prenatal Visit___________

BABY BASICS:

Due Date ____________ Group Beta Strep(GBS)_________

Sex of baby ___________

Name of Baby(if Known)_______________________

Have you taken Childbirth Education Classes? _______ If yes, location & instructor _________________

Have you taken a Breastfeeding Class?______ If yes, location & instructor________________________

Other classes taken in preparation:____

Who have you invited to your birth?____

Do you have good help after the birth (who and how long)?______________________________________

How do you plan to feed your baby? __Breast ___Bottle __Both

Pain management during labor: __IV medications __Epidural __none __other(explain)_______________

In general, how have you felt with this pregnancy?____

____

PREGNANCY HISTORY:

Total # of pregnancies____ Full Term ____ Preterm____ Abortions____ Miscarriages____Ectopic___

Multiple Births___ Living___

#	Delivery Date	# Weeks Pregnant	Group B Strep (+/-)	Vaginal or Cesarean	Spontaneous/ Induced Labor	Gender	Birth Weight	Anesthesia Type	Complications (yes or no)
1.									
2.									
3.									
4.									
5.									
6.									
7.									

Complications Comments: ____

____

____

____

HEALTH HISTORY:

List all medications/herbal supplements:____

____

Drug Allergies/Reactions:____

Height__________ Pre-pregnancy Weight_________

Do you Drink alcohol? ______ If yes, how often and how much?__________________________________

Do you smoke cigarettes? _______ If yes, how many packs per day?______________________________

Does your partner smoke? ________If yes, how many packs per day?______________________________

Do you use illicit/street drugs?________ If yes, list and how often?_______________________________

MEDICAL HISTORY:

Use a check mark to indicate if you have/have had the following conditions before or during pregnancy:

Condition		Condition		Condition	
Asthma		Kidney Dysfunction		Fibroids	
Pneumonia		Liver Disease		Endometriosis	
Tuberculosis(TB)		Diabetes		Infertility	
Lung Disorders		Thyroid Disorder		Gynecological Problems	
Anemia		GI Disease		Psychological Disorder	
Blood Clot/Blood Disorder		Muscular/skeletal Disorder		Eating Disorders	
Blood Transfusion		HPV		Anxiety/Depression	
Heart Problems		HIV/AIDS		Abuse/Trauma	
High Blood Pressure		Sexually Transmitted Disease (STDs)		MRSA/Other Infection	
Neurological Disorder		Herpes		Hospitalization/Surgery	
Seizures		Polycystic Ovarian Syndrome(PCOS)		Anesthesia Complications	

If answered yes to any of the above, please describe:____

____

____

Do you have any other significant medical history?____

____

____

What are your expectations for the doula's role during your labor/birth? _________________________

____

What else would you like me to know about your history, hopes, dreams, fears, strengths, or limitations?____

____

What is your vision for bringing your baby into this world? ____________________________________