Health Freedom
Midwifery Care

Chris Duffy, LM
281-732-7816

CONTACT INFO

Home: _____

Cell: _____

Work: _____

Other: _____

Other: _____

MOTHER

Full Legal Name: _____ Maiden: _____

Age: _____ DOB: _____ Ed. Grade or degree: _____

Race: _____ SSN: _____ Occ _____ Industry _____

Smoker: ____ Blood Type: _____ State of Birth: _____

FATHER

Full Legal Name: _____ Suffix: _____

Age: _____ DOB: _____ Ed. Grade or degree: _____

Race: _____ SSN: _____ Occ _____ Industry _____

Smoker: ____ Blood Type: _____ State of Birth: _____

Address: _____ City: _____ Zip: _____

Mailing Address, if different: _____ City: _____ Zip: _____

Email Address: _____ Referred by: _____

Directions:

Allergies:

Notable Test Results:

Pregnancy History: G: _____ P: _____ AB/MISC: _____ LMP: _____ NML/ABNML EDD: _____

#	Mo/Yr	Wks	Hrs	Spon/Ind - Meds - Hosp/Home - Tear/Epis/CS - BWT/Sex - Feeding - Name - Other

Birth desires/Concerns: _____

Attitude of Relatives/Friends: _____

Who will attend? _____

Who will provide PP Help? _____

OB: _____ # _____ Pediatrician: _____ # _____ Other: _____ # _____

MEDICAL HISTORY

Name:	First	Middle	Last	Maiden	Date	Home Phone	
Race	Religion		Yrs. Educ.	Marital Status	Occupation	Date of Birth	State of Birth
Address:	Street		City		ZIP	Work Phone	
Father of Baby:	First	Middle	Last	Race	Yrs. Educ.	Date of Birth	State of Birth / Occupation
Mother's SS#		Fathers SS#		SS# for Baby?	Yes ☐ No ☐	Referred By:	
Emergency contact:	Name		Phone	Relationship	Your e-mail	Your Cell#	

Please answer the following questions which will help determine if there are potential problems which should be discussed further.

FAMILY HISTORY - *Indicate if anyone in your immediate family has ever had any of these.*
Who? When?

- ☐ High Blood pressure_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Twins_____
- ☐ Severe emotional problems_____
- ☐ Alcohol/drug abuse_____
- ☐ Other_____

FATHER OF BABY - *Indicate if the baby's father has ever had any of these.*
When?

- ☐ Sexually transmitted disease_____
- ☐ Herpes: ☐ Genital ☐ Oral
- ☐ Severe emotional problems_____
- ☐ Alcohol/Drug abuse_____
- ☐ Tobacco use_____
- ☐ Other health problems? _____
  _____

YOUR MOTHER'S HISTORY - *Please answer the following regarding your mother:*

- ☐ No. of pregnancies_____
- ☐ No. of births_____
- ☐ Miscarriages_____
- ☐ Complications?_____

Did she take DES while pregnant with you?
☐ Yes ☐ No ☐ I don't know

PREVIOUS PREGNANCY OUTCOMES

Please complete this table regarding your own pregnancies – first to last ***– including any miscarriages or abortions***

Date	No. of Weeks	Where	Length Labor	Weight	Sex	Comments/Problems	Name

Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?

Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?

Yes No Are you and the FOB related by blood? (e.g. cousins)

Yes No Are you or the FOB from any of these ethnic/racial groups? (circle)
Jewish Black/African Asian Mediterranean

Yes No Have you or the FOB ever had hepatitis or jaundice?

Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?

Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion or had bisexual relations?

Yes No Do you think you are at increased risk for AIDS/HIV?

Yes No Have you ever had anorexia, bulimia or other eating disorders?

Yes No Have you ever been in an abusive relationship, including now, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will?

Yes No Have you ever had severe emotional problems?

Yes No Have you ever been on any medication for psychological problems?

Yes No Has anyone ever told you, or do you think you have ever used alcohol or drugs excessively?

NAME_____

MEDICAL HISTORY - *Please indicate if you have ever had any of these, and when:*

- ▯ Severe headaches_____
- ▯ Eye/vision problems_____
- ▯ Ear/hearing problems_____
- ▯ Dental problems_____
- ▯ Thyroid problems_____
- ▯ Rheumatic fever_____
- ▯ Blood clotting problems_____
- ▯ Anemia_____
- ▯ Hemorrhage_____
- ▯ High blood pressure_____
- ▯ Varicose veins_____
- ▯ Hemorrhoids_____
- ▯ Tuberculosis_____
- ▯ Asthma_____
- ▯ Skin disorders_____
- ▯ Stomach problems_____
- ▯ Ulcers_____
- ▯ Chicken Pox_____
- ▯ Bowel problems/colitis_____
- ▯ Blood in stool_____
- ▯ Gall bladder problems_____
- ▯ Liver problems_____
- ▯ Hepatitis_____
- ▯ Diabetes_____
- ▯ Hypoglycemia_____
- ▯ Bladder infection_____
- ▯ Kidney infection_____
- ▯ Urinary surgery_____
- ▯ Urethral dilation_____
- ▯ Aching joints_____
- ▯ Pelvic/back injuries_____
- ▯ Seizures_____
- ▯ Cancer_____
- ▯ Hospitalizations_____
- ▯ Surgeries_____
- ▯ Other_____

_____

Do you have any allergies? ▯ Yes ▯ No

Please List:_____

_____

GYNECOLOGIC HISTORY:

Age at first period_____ How often do you get your period?

How many days does it last?_____ _____

Is it regular? ▯ Yes ▯ No Is it painful? ▯ Yes ▯ No

When was your last Pap smear? _____

Was it normal? ▯ Yes ▯ No

Have you ever had an abnormal Pap? ▯ Yes ▯ No

Please explain_____

Have you ever had any of the following? When?

- ▯ Yeast_____
- ▯ Trichomonas_____
- ▯ Group B Strep_____
- ▯ Bacterial vaginosis_____
- ▯ Chlamydia_____
- ▯ Gonorrhea_____
- ▯ Syphilis_____
- ▯ PID/Pelvic Infection_____
- ▯ Genital Sores_____
- ▯ Herpes ▯ Genital ▯ Oral
- ▯ Condyloma (warts)_____
- ▯ Cervicitis_____
- ▯ Cervical Surgery_____
- ▯ Cervical polyp_____
- ▯ Ovarian cyst_____
- ▯ Fibroids_____
- ▯ Endometriosis_____
- ▯ Abnormal bleeding_____
- ▯ Uterine surgery_____
- ▯ Breast Lump(s)_____
- ▯ Breast surgery_____
- ▯ Infertility
- ▯ Other_____

PRESENT PREGNANCY:

1st day of **L**ast **M**enstrual **P**eriod_____ Normal? ▯ Yes ▯ No

Date of pregnancy test (if known) _____

Do you know when the baby was conceived?_____

Have you felt the baby move yet? ▯ Yes ▯ No When?_____

Were you using birth control when you conceived? _____

What kinds of birth control have you used in the past? Any problems?

_____

_____

Please indicate if you have had any of the following problems during this pregnancy:

- ▯ Nausea_____
- ▯ Vomiting_____
- ▯ Fever_____
- ▯ Infections_____
- ▯ Headache_____
- ▯ Dizziness_____
- ▯ Indigestion_____
- ▯ Leg cramps_____
- ▯ Rash_____
- ▯ Backache_____
- ▯ Swelling_____
- ▯ Constipation_____
- ▯ Urinary complaints_____
- ▯ Abdominal/pelvic pain_____
- ▯ Vaginal bleeding_____
- ▯ Vaginal discharge_____
- ▯ Bleeding gums_____
- ▯ Varicose veins_____
- ▯ Hemorrhoids_____
- ▯ Diarrhea_____
- ▯ Depression_____
- ▯ Family problems_____
- ▯ Work problems_____
- ▯ Other_____

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

- ▯ Tobacco_____
- ▯ Alcohol_____
- ▯ Caffeine_____
- ▯ Marijuana_____
- ▯ Cocaine_____
- ▯ Street drugs_____
- ▯ Other meds._____
- ▯ Non-pres. Drugs_____
- ▯ Vitamins_____
- ▯ Herbs_____
- ▯ Fumes/sprays_____
- ▯ X-rays_____
- ▯ Ultrasound_____
- ▯ Measles/viruses_____
- ▯ Travel_____
- ▯ Vaccinations_____
- ▯ Cats_____
- ▯ Other_____

What kinds of food do you usually eat? Check two:

▯ meat & potatoes ▯ whole foods & meat ▯ junk food

▯ ovo-lacto vegetarian ▯ vegan ▯ macrobiotic

▯ other (describe)_____

_____

What do you generally do for exercise?_____

_____

_____

Please tell me briefly why you have chosen a home birth?_____

_____

_____

_____

Chris Duffy
903 Forsythe Lane
Houston, Texas 77073

Bill for Initial Prenatal Visit? Y__ N__ Date of Initial Visit _____ Do Verification? Y___ N___

Insurance Eligibility Verification Form **DATE_____**

_____ _____ _____
Client's Name **Birth Date** **Due Date of Birth**

_____ _____ **G__ P__ LMP_____**
Client's Address **Phone Number**

_____ _____
Insurance Company **Phone Number**

_____ _____ _____
Claims Address *Rep Name* *Time*

_____ _____ _____
ID or Policy Number **Group Number** *Plan Name*

_____ _____ _____
Name of Insured *Insured's Date of Birth* *Relationship to Client*

_____
Employer of Insured

==========**DO NOT WRITE BELOW THIS LINE**==========
___HMO ___PPO ___EPO ___QPOS ____POS ___Standard Medical ___Self Funded Plan

Birth Center Y___% N__ **Home Birth Y___% N__** **Midwife? Y___% N__**

_____ _____ _____
$ Deductible **COPAY** **$ of Deductible met**

_____ _____
Out of Pocket **Effective Date**

Ultrasounds? Y___ N___ **Deductible carry over? _____** **Global Billing + Initial___ or Itemized Billing___**

Precert Necessary for Homebirth? Y__N__ Precert #_____ Precert Phone#_____

NOTES: _____

_____

_____

_____