# Initial Visit & Health History

Pineapple Babies Birth Services

Date: ____________________ Due Date: ____________________ Client Number: ____________________

Full Legal Name: ______________________________________________ Maiden Name: ______________________________

Preferred name: ______________________________ DOB: ___________ Place of Birth: ________________________________

Address:________________________________________________________________________________________________

City: ________________________ State: _______ Zip: _________County: _____________________ Inside city limits? ______

Primary Phone: ________________________________________ Secondary Phone________________________________________

Email:__________________________________________________________________________________________________

Social Security Number: _______________________ Occupation: __________________________________________________

Highest Education: ________________________________________ Degree: __________________________________________

Race/Ethnicity: _____________________________________________ Hispanic/Latin Origin: YES or NO If Yes, specify __________

Are you currently married? YES or NO

Were you married at the time of conception? YES or NO

Is your husband the baby's father? YES or NO

Previous prenatal care provider? _____________________________________________________________________________

Date of First Prenatal Visit: ___________________ How many visits have you had? __________ Date of LMP: _________________

**Partner Information:** Is it ok to share medical information with partner? _____________________

Full Legal Name: ______________________________________________ Maiden Name: ______________________________

Preferred name: ______________________________ DOB: ___________ Place of Birth: ________________________________

Address:________________________________________________________________________________________________

City: ________________________ State: _______ Zip: _________County: _____________________ Inside city limits? ______

Primary Phone: ________________________________________ Secondary Phone________________________________________

Email:__________________________________________________________________________________________________

Social Security Number: _______________________ Occupation: __________________________________________________

Highest Education: ________________________________________ Degree: __________________________________________

Race/Ethnicity: ______________________________________ Hispanic/Latin Origin: YES or NO If Yes, specify ________________

Date: ______________________ Client Number: ______________________

Do you take any medications or nutritional supplements? If yes, please list. ____________________________________________________

______________________________________________________________________________

Are you allergic to any foods or medications? YES or NO If yes, please specify:________________________________________________

______________________________________________________________________________

Have you, your immediate family, or your partner experienced:

| Have you ever experienced | You or Immediate Family Member | Who? | Partner |
|---|---|---|---|
| Diabetes | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Genetic Disorders or Anomalies | | | |
| Mental Health Concerns | | | |
| Epilepsy | | | |
| Twin Births | | | |
| Labors less than 4 hours long | | | |

Have you ever had or experienced (if yes, please provide details):

| No | Yes | Have you ever experienced? | Details |
|---|---|---|---|
| | | Severe or frequent headaches | |
| | | Visual or hearing problems | |
| | | Thyroid or hormone problems | |
| | | Hepatitis or liver disease | |
| | | Kidney disease or infection | |
| | | Respiratory disease or asthma | |
| | | Urinary tract, bladder, yeast, or uterine | |
| | | Infertility or PCOS | |
| | | Sexually transmitted diseases, genital sores or warts | |
| | | Uterine fibroids, ovarian cysts | |
| | | Blood clotting disorder, anemia | |
| | | Scoliosis, chronic back pain | |
| | | Varicose veins | |
| | | Surgery, specifically breast, cervical, uterine, or back surgeries | |

Date: ______________________ Client Number: ______________________

## Obstetric History

Are your menstrual cycles normal? YES NO If no, please explain: ____________________________________________

How long are your normal menstrual cycles? _________ First day of your last normal period? ___________ Age at onset? _____________

What type of pregnancy test did you have? BLOOD or URINE Is this pregnancy the result of IUI or IVF? _______________________

Do you know the date of conception? _________ Did you use any form of contraception? YES NO

If yes, please describe what kind and how long used:________________________________________________________

## Pregnancy History (including miscarriages and abortions, continue at bottom of next page if needed)

| Pregnancy # | Baby's Name | Date of Birth | Birth Weight | Length | Weight gain | Out of Hospital? | Comments or Concerns |
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Date: ______________________ Client Number: ______________________

In previous pregnancies, did you experience any of the following (if yes, please describe):

_______ Urinary tract or other infections? ____________________________________________

_______ Gestational diabetes? ____________________________________________

_______ What testing did you have? ____________________________________________

_______ Were you Group B Strep positive? If so, how did you manage the risk? ______________________

_______ Any medications used? ____________________________________________

During previous labors and births, please give details regarding:

_______ Any medications used? ____________________________________________

_______ Episiotomy/tears? ____________________________________________

_______ Breastfeeding issues? ____________________________________________

_______ Other complications? ____________________________________________

Have you experienced any of the following in this pregnancy?

_______ Abdominal pain? ____________________________________________

_______ Bleeding/spotting? ____________________________________________

_______ Severe vomiting, nausea, or fatigue? ____________________________________________

_______ Headache or visual disturbances? ____________________________________________

_______ Other:____________________________________________

Do you have any other health history or concerns of which you think I should be aware? ______________________

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