MOTHER Pregnancy and Medical History MOTHER

Date_____ **YOUR NAME:** _____ **YOUR DATE OF BIRTH** _____

WHO REFERRED YOU to us? _____

***THIS BIRTH*: CIRCLE where baby was born**:

Home Birth center Hospital Other _____
Name, hospital or birthing center _____

CIRCLE type of delivery

Vaginal C-section VBAC

ANY PROBLEMS with this pregnancy, labor, birth?

(We will discuss these issues in more detail if needed)

	Y/N	You can be brief
Pregancy		
Labor		
Delivery		
Got Epidural?		

Medications

Medications *during this pregnancy* _____
_____
_____
_____

Medications *you're taking* ***NOW*** _____
_____
_____
_____

FAMILY HISTORY

Do you have any relatives who have breastfed?_____
_____

YOUR CHILDREN

Name	Birthday	Breastfed? How long?	General Health

YOUR FAMILY / WORK LIFE

Who lives with you? Please CIRCLE all that apply
Parent(s) Spouse #___Children Other_____
Paid work outside home? Full-time/Part-time? _____
Occupation _____
Your education: HS / some college/ degree? _____
Plans for returning to work, date?_____

YOUR PAST MEDICAL HISTORY

Are you in general good health? **YES NO**

_____
_____

Number of pregnancies you've had?_____
Any miscarriages or terminations? _____

PAST AND CURRENT MEDICAL PROBLEMS

Please check	**Y/N**	***Treatment now?***
Asthma		
Diabetes		
Mood issues		
High blood pressure		
Thyroid problems		
joint/back/muscle pain		
Breast problems		
Other:		
Allergies		
Food		
Medicines you're allergic to:		

PRIOR SURGERY, INJURIES, HOSPITALIZATION

Please list	Year(s)	Hospital
Breast surgery? What kind?		
Caesarian sections		
Other Surgery, Injuries or hospitalizations		