NORTHERN SUN
FAMILY HEALTH CARE

SARAH ACKERLY, N.D., CPM

ALICIA THOMAS, N.D.

Hello,

We are delighted you are considering having a home birth or birthing at the birth center. At your consultation visit, we will be exploring what it means to birth outside of the hospital. Please bring any questions you have concerning your pregnancy and birth to discuss at this appointment. We believe it is important for both partners to be present at this visit if at all possible, so please make every effort to schedule a time when you both can attend.

After a consultation most parents like to go home and think things over before they make a decision about their place of birth and care providers. If you are certain that you would like to have us as your midwives, we can make an appointment right away for your next visit. If you need to discuss your options with your partner, we encourage you to do so before calling back to make your next appointment.

An important element of midwifery care is the establishment of a warm and open relationship. We look forward to meeting you and your partner or husband.

Sincerely,

Sarah Ackerly, ND, CPM

53 Main Street, Topsham, ME 04086 TEL (207) 798-3993 FAX (207) 798-3999

PERSONAL AND MEDICAL HISTORY

We know this form may take some time, but this information will allow us to provide you with the best possible care. We will go over this together at your visit. If you have any questions or don't understand something, please make a note and we can discuss it. This information will be kept completely confidential.

Name_____ Today's Date_____

Date of Birth_____ Age_____ Social Security Number _____

Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-Mail Address_____

Occupation_____ Education _____ Religious/spiritual preference_____

Married _____ Partner _____ Single _____ Separated _____ Divorced _____ Widowed _____

Husband/Partner's Name_____ E-Mail Address _____

Date of Birth_____ Age_____ Social Security Number _____

Occupation_____ Education _____ Religious/spiritual preference_____

Home Phone_____ Work Phone_____ Cell Phone_____

Insurance Co._____

How did you hear about Northern Sun? _____

Please tell us your thoughts or feelings on why want to have your baby at __ home or at __ The Birth Center?
Mother:_____
_____
_____
_____
_____

Father/Partner:_____
_____
_____
_____
_____
_____

Have either of you ever seen a baby being born?_____

Mother's Family History Check if anyone in your immediate family (grandparents, parents & siblings) has ever had these conditions:

_____ Cancer
_____ Diabetes
_____ Alcohol/drug problems
_____ Twins, triplets
_____ Hepatitis/jaundice
_____ Heart disease
_____ Epilepsy
_____ Severe emotional problems
_____ Allergies
_____ Varicose veins
_____ High blood pressure
_____ Blood clotting problems
_____ Tuberculosis
_____ Birth defects/congenital anomalies

Were your mother's labors long, average or short _____ Any difficulties?_____
Your sister's labors?_____
How much did you weigh at birth?_____ Were you breastfed? _____
Did your mother take DES (diethylstilbestrol) when she was pregnant with you? _____

Father's Family History Check if any of these ever happened to you or anyone in your family:

_____ Heart disease
_____ Diabetes
_____ High blood pressure
_____ Hepatitis/jaundice
_____ Tuberculosis
_____ Birth defects/congenital anomalies

Mother's Medical History Please check if you ever had any of these:

_____ Hospitalizations
_____ Rheumatic fever
_____ Mononucleosis
_____ Hemorrhage
_____ Stomach problems
_____ Aching joints
_____ Breast biopsy or lumps
_____ Major illnesses
_____ Diabetes
_____ Hepatitis/jaundice
_____ Anemia
_____ Asthma
_____ Hypoglycemia
_____ Skin problems
_____ Blood in stool
_____ Lyme disease
_____ Accidents
_____ Thyroid problems
_____ Eye or vision problems
_____ Varicose veins or phlebitis
_____ Bowel problems
_____ Seizures, epilepsy
_____ Hernia
_____ Surgeries
_____ Urinary tract infections
_____ Severe headaches
_____ High blood pressure
_____ Water retention
_____ Pelvic or back injuries
_____ Appendicitis
_____ Food or other allergies
_____ MRSA (staph infections)
_____ Childhood diseases
_____ Cancer
_____ Ear or hearing problems
_____ Tuberculosis
_____ Liver problems
_____ Jaundice
_____ Blood clotting problems
_____ Blood transfusions
_____ Kidney or bladder infections
_____ Dental problems
_____ Hemorrhoids
_____ Gall bladder problems
_____ Emotional problems
_____ Scoliosis
_____ Allergies to medicines
_____ Other

_____

_____

How would you describe your overall health?_____
How would you describe your diet?_____
Do you get any form of regular exercise?_____
What is your usual non-pregnant weight?_____ Height_____
Do you have a high, moderate or low stress life?_____
Have you ever experienced large changes in your weight in one year?_____
Have you ever had anorexia, bulimia or any eating problems?_____

Do you bruise easily?_____
Do you regularly use antacids or laxatives?_____

Gynecological History

Age at 1st period _____ How many days apart is your menstrual cycle _____ Regular or irregular?
Do you have menstrual cramps _____ How many days do you bleed? _____ Heavy/Medium/light
Do you bleed between periods? _____ Do you have PMS symptoms? _____
Please check if you have ever had the following:

_____ Infertility	_____ Cervicitis	_____ Cervical surgery
_____ Cervical polyp	_____ Ovarian cyst	_____ Fibroids
_____ Endometriosis	_____ Abnormal bleeding	_____ Uterine surgery
_____ Breast lumps	_____ Breast surgery	_____ Yeast infection
_____ Trichomonas	_____ Chlamydia	_____ Gardnerella
_____ Herpes (___oral ___genital)	_____ Gonorrhea	_____ Syphilis
_____ Pelvic inflammatory disease	_____ Genital warts	_____ Genital sores
_____ Other		

Has the father of the baby ever had:

_____ Herpes (___oral ___genital)	_____ STIs	_____ Tobacco use
_____ Blood transfusions	_____ Urethritis	_____ Alcohol or drug use
_____ Severe emotional problems	_____ Hepatitis/jaundice	

When was your last pap smear?_____ Have you ever had an abnormal pap?_____
Do you do monthly breast exams? _____
Have you had more than three sexual partners in the last five years? _____
Have you used drugs intravenously? _____
Have you ever had a sexual partner who used any drug intravenously or had a blood transfusion?_____
Are you now or have you ever been abused, whether emotionally intimidated or physically beaten, injured or mad to take part in sexual activities against your will? _____
Is there any thing about the development of your sexuality that you would like to discuss?_____

Please list the methods of contraception that you have used, and whether you liked it or not. Put a star next to the most recent method used.

_____
_____
_____
_____

Obstetric History

Please describe below each time you have been pregnant, including miscarriages, and abortions starting with the first pregnancy:

Name	Birthday	Due Date	Length of Labor	Where	Wt Gain	Infant Wt	Complications
1.							
2.							

3.
_____
4.
_____
5.
_____
6.
_____

Present pregnancy

Date of your last menstrual period?_____ Is this sure or an estimation:_____
Was the amount and length of bleeding in that period normal for you?_____
If not when was your previous period?_____ Do you know the date you conceived?_____
Is this a planned, an "okay if it happens" or an unplanned pregnancy?_____
How are you feeling about this pregnancy?_____
Did you have a positive pregnancy test (either lab or home)_____Date_____
Are you and the father of this baby related by blood, (for example: cousins)_____
Have you breastfed any of your previous babies? _____Any problems?_____
_____

Please check if you've had any of the following problems during this pregnancy:

_____ Nausea	_____ Vomiting	_____ Fever
_____ Headache	_____ Dizziness/fainting	_____ Varicose veins
_____ Hemorrhoids	_____ Backache	_____ Swelling, edema
_____ Constipation	_____ Diarrhea	_____ Unusual fatigue
_____ Visual problems	_____ Urinary complaints	_____ Abdominal/pelvic pain
_____ Vaginal discharge/odor	_____ Indigestion	_____ Leg cramps
_____ Rash	_____ Loneliness	_____ Depression
_____ Family/relationship problem	_____ Work problems	_____ Sleeping problems
_____ Other		

Please indicate if you have used or have been exposed to the following in this pregnancy:

_____ Tobacco/tobacco smoke	_____ Occupational exposure	_____ Alcohol
_____ Caffeine	_____ Recreational drugs	_____ Over-the-counter medications
_____ Prescription medications	_____ Herbal medications	_____ Vitamins
_____ Fumes/sprays	_____ X-rays	_____ Infectious diseases
_____ Hot tub or sauna	_____ Vaccinations	_____ Cat feces/bird droppings
_____ Other		

Are there any particular ethnic, cultural, religious, or personal preferences for your care that you would like us to know about?

_____
_____
_____
_____

Please use this space for any other information that you'd like to discuss or that is important to you or your partner/husband:

_____

_____

_____

_____

_____

_____

Mother's signature _____ Date _____

Husband/partner's signature _____ Date _____