

Case History for Pregnant Mothers

Name: _____

Prenatal history:

- 1) Is this your first pregnancy? _____
- 2) How many other births have you had? _____
- 3) How many weeks pregnant are you now? _____
- 4) Have you experienced any traumas during this pregnancy? (accidents, falls) _____
Please describe _____
- 5) Any medications taken during this pregnancy? _____
- 6) Do you smoke or drink alcohol? _____
- 7) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? _____
- 8) Please list dates, frequency and reason for these procedures:

- 9) How has your diet been during this pregnancy? _____
- 10) Has there been any stressful events in your life during this pregnancy? _____

- 11) What are your most significant fears associated with this birth? _____

- 12) Who is your birth care provider? _____
- 13) Will you have someone with you at birth for support (other than birth care provider)
Please specify who _____
- 14) Where do you plan on delivering? _____
- 15) Have you put together a birth
plan? _____

Previous Birth History:

1) **Place of birth:** hospital, birthing center, home.

2) **Delivering Practitioner:** OB/Gyn, Certified Nurse Midwife, Certified Practicing Midwife, Lay Midwife

3) **Position of Delivery:** Lithotomy position (on back with feet up), On Your Side, Kneeling, Squatting, Other?_____

4) **Was labor induced?** (Contractions were stimulated *prior* to the natural onset of labor)

Yes No Unknown

If yes, specify type: Pitocin, Prostagland Gel (applied to your cervix), Unknown

5) **Were your membranes ruptured by your care provider?** Yes No Unknown

6) **Were contractions stimulated intravenously with pitocin *once* labor started?**

Yes No Unknown

7) **Did you receive any pain medications or anesthesia?** Yes No Unknown

Please specify type used_____

If you had an epidural, how many centimeters were you dilated when it was administered?_____

8) **Did you experience back pain during labor?** Yes No Unknown

9) **Did you deliver vaginally?** Yes No

10) **Baby presentation at time of delivery:** Normal, Posterior, Brow, Facial, Breech,

If breech, specify type: Footling, Frank, Complete, Kneeling

Was there any visible injury to your baby? Yes No Unknown

If so, where on your baby was the injury sustained?_____

11) **Did your care provider assist delivery with his/her hands?** Yes No Unknown

Was there any turning of the neck, or traction (pulling) applied to the neck?

Yes No Unknown

12) **Were operative devices used to facilitate the birth?** Yes No Unknown

Which type? Forceps Vacuum Extraction

If yes, was there any visible signs of injury to your baby? Yes No Unknown

If yes, where was the injury sustained?_____

13 **Was there a birthing coach present?** husband, doula, friend, other

If other, please specify:_____.

14 **At what week of pregnancy was your baby born?**_____