MIDWIVES OF NEW JERSEY
Serving Women, Honoring Birth.

Medical History

Date:_____

Name: _____Date of Birth: _____

Address: _____

Phone Number: _____Email: _____

ALLERGIES:_____

Do you have or had any of the following, please check off:

NEUROLOGICAL

- o Migraines
- o Frequent headaches
- o Concussion/head injury
- o Dizziness/fainting
- o ADD/ADHD
- o Seizures/Epilepsy
- o Other_____
- o Denies all the above

EYES

- o Eye injury/Disease
- o Other_____
- o Denies all the above

EAR, NOSE & THROAT

- o Seasonal allergies
- o Hearing loss/deafness
- o Frequent ear infections
- o Sinus infections
- o Denies all the above

LUNGS

- o Asthma
- o Exercise-induced asthma
- o Other_____
- o Denies all the above

INFECTIONS

- o Chicken Pox- diseased or vaccine
- o Lyme's disease
- o Cold sores
- o Mononucleosis
- o Positive TB skin test
- o Other_____
- o Denies all the above

CARDIOVASCULAR

- o High blood pressure
- o Heart Murmur
- o History of palpitations
- o Other_____
- o Denies all the above

GASTROINTESTINAL

- o Irritable bowel/Colitis
- o Gallbladder problems
- o Hemorrhoids
- o Hernia
- o Other_____
- o Denies all the above

ENDOCRINE

- o Diabetes
- o Thyroid disease
- o Other_____
- o Denies all the above

GENITOURINARY

- o Urinary tract infections
- o Kidney stones/disease
- o Other_____
- o Denies all the above

MUSCULOSKELETAL

- o Arthritis
- o Bone Fractures
- o Back/disc problems
- o Scoliosis
- o Other_____
- o Denies all the above

BLOOD DISORDERS

- o Anemia/thalassemia
- o Sickle cell trait/disease
- o Clotting disorder
- o Other_____
- o Denies all the above

MENTAL HEALTH

- o ADHD/ADD
- o Alcohol/drug abuse
- o Anorexia and/or Bulimia
- o Anxiety/panic disorder
- o Depression
- o Learning disability
- o Suicide attempt
- o Other_____
- o Denies all the above

DERMATOLOGY

- o Acne
- o Eczema
- o Other_____
- o Denies all the above

SOCIAL HISTORY

- o Tobacco
- o Alcohol
- o Recreational drugs_____
- o Other prescription drugs_____
- o History of abuse type & frequency_____

  _____
- o Regular exercise_____
- o Denies all the above

WOMEN'S HEALTH HISTORY

- o Age menstrual period began_____
- o Age of menopause_____
- o Frequency of period_____
- o # of days of flow_____
- o PMS
- o Sexually transmitted infections_____
- o Abnormal pap smears
- o Breast lumps/disease
- o Birth control methods used_____

  _____

PREGNANCY HISTORY

- o # of Pregnancies_____
- o # of Births_____
- o # of Miscarriages_____
- o # of Terminations_____
- o Pre-eclampsia
- o Gestational diabetes
- o Preterm birth
- o Vaginal births
- o Cesarean sections
- o VBAC's
- o Episiotomy/3rd or 4th degree laceration
- o Postpartum hemorrhage
- o Postpartum depression
- o Total # of years breastfeeding_____
- o Other pregnancy complications_____

SURGICAL HISTORY	DATE
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

Please list all medications

_____

_____

_____

_____

_____

ANY OTHER MEDICAL HISTORY

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

_____

_____

_____