Community Midwifery Services Client Information Form

Client Information

Full Legal Name: _____
First *Middle* *Last* *Nickname / Suffix*

Address: _____ Inside City Limits Y / N

City: _____ State: _____ Zip: _____ County: _____

Phone: *home* _____ *cell* _____ *work* _____ *texting capability* Y / N

Date of Birth: _____ Place of Birth: _____

Social Security # ___ — ___ — _____ Email: _____

Current Relationship Status: _____ Maiden Name: _____

Primary Languages: _____ Race/Ethnicity: _____ Hispanic/Latin Origin Y / N

Highest Education: _____ Degree: _____ Religious or Spiritual Affiliation? _____

How did you find out about CMS? _____

Partner Information

Full Legal Name: _____
First *Middle* *Last* *Suffix*

Address: _____ Inside City Limits Y / N

City: _____ State: _____ Zip: _____ County: _____

Phone: *home* _____ *cell* _____ *work* _____ *texting capability* Y / N

Date of Birth: _____ Place of Birth: _____

Social Security # ___ — ___ — _____ Email: _____

Primary Languages: _____ Race/Ethnicity: _____ Hispanic/Latin Origin Y / N

Highest Education: _____ Degree: _____ Religious or Spiritual Affiliation? _____

Primary Insurance Holder

Employer: _____ Employer Phone: _____

Insurance Company: _____ Insurance Address: _____

Insurance Phone: *benefit verification #* _____ *claims #* _____

Policy Holder _____ Date of Birth _____ SSN _____

Policy # _____ Group # _____ ID # _____

Additional

If you do not have insurance, how do you plan to pay this account? Cash Check

Person financially responsible for this account: _____

Emergency Contact Person: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Name _____

Please thoroughly complete this form in preparation for your initial visit. All information is kept completely confidential. In the event your records are copied for another care provider, this page will not be included.

Personal Medical History

- ▫ Frequent Headaches
- ▫ Migraines
- ▫ Eye / Vision Problems
- ▫ Dental Problems
- ▫ Thyroid Disorder
- ▫ Rheumatic Fever
- ▫ Blood Clotting Disorder
- ▫ Anemia
- ▫ Hemorrhage
- ▫ High Blood Pressure
- ▫ Varicose Veins
- ▫ Hemorrhoids
- ▫ Tuberculosis
- ▫ Asthma
- ▫ Stomach Problems
- ▫ Ulcers
- ▫ Bowel Problems
- ▫ Celiac Disease
- ▫ Colitis
- ▫ Blood in Stool
- ▫ Giardia
- ▫ Gall Bladder Disorder
- ▫ Diabetes
- ▫ Hypoglycemia
- ▫ Hyperglycemia
- ▫ Bladder Infection
- ▫ Kidney Infection
- ▫ Urinary Tract Infection
- ▫ Urethral Dilation
- ▫ Liver Disorder
- ▫ Malaria
- ▫ Dengue Fever
- ▫ Hepatitis Virus
  - ▫ A B C D E
- ▫ Aching Joints
- ▫ Pelvic / Back Injury
- ▫ Seizures
- ▫ Hospitalization
- ▫ Surgeries

Allergies

- ▫ Seasonal Allergies
- ▫ Food Allergies
- ▫ Latex
- ▫ Medications

_____

_____

- ▫ Do you have any severe allergy which requires you to carry an Epi-Pen?

Exposures

- ▫ Cigarettes per day
- ▫ Second Hand Tobacco
- ▫ Alcohol
- ▫ Caffeine
- ▫ Marijuana
- ▫ Cocaine
- ▫ Street Drugs
- ▫ Prescription Drugs
- ▫ Non Prescription Drugs
- ▫ Vitamins
- ▫ Herbs
- ▫ Fumes / Sprays
- ▫ X-Ray
- ▫ Ultrasound
- ▫ Measles
- ▫ Vaccinations
- ▫ Cats or Birds

Family Medical History (immediate)

- ▫ High Blood Pressure
- ▫ Heart Disease
- ▫ Kidney Disease
- ▫ Cancer
- ▫ Diabetes
- ▫ Seizure Disorder
- ▫ Substance Abuse
- ▫ Severe Emotional Problems

Partner Medical History

- ▫ Sexually Transmitted Infection
- ▫ Urethritis
- ▫ Severe Emotional Problems
- ▫ Substance Abuse
  - ▫ Alcohol
  - ▫ Drug
- ▫ Tobacco Use
- ▫ Other: _____

Maternal History (if known)

- ▫ Number of Pregnancies _____
- ▫ Number of live births _____
- ▫ Number of miscarriages _____
- ▫ Your birth weight _____
- ▫ Any complications in your mother's birth history?

_____

Ethnic Backgrounds Do either biological parent have any of the following ethnic origins?

- ▫ Caucasian / White
- ▫ African American / Black
- ▫ South / Southeast Asian
- ▫ European / Eastern European
- ▫ Mediterranean
- ▫ Jewish

Questionnaire Please mark if any of the following health considerations are applicable to you.

Does either biological parent :

- ▫ have a history of a baby with a birth defect or mental retardation?
- ▫ have family members with birth defects / conditions diagnosed as genetic or inherited?
- ▫ think there is an increased risk for having a baby with a birth defect or genetic problem?
- ▫ have any blood relation (e.g. cousins) to each other?
- ▫ have a history of intravenous (IV) drug use or blood transfusion?
- ▫ have a history of sexual partner(s) who used drugs IV or who had a blood transfusion?
- ▫ have an increased risk for hepatitis or HIV/AIDS?
- ▫ Have you ever experienced dramatic fluctuation in weight?
- ▫ Have you ever had an eating disorder such as anorexia or bulimia?
- ▫ Is there anything about your sexuality you would like to discuss?
- ▫ Have you ever had severe emotional problems?
- ▫ Has anyone ever told you, or do you think that you have ever used alcohol or drugs excessively?
- ▫ Do you feel a need to discuss with a midwife privately any history of abusive relationship in the past or present (including physical abuse such as having been beaten or injured, emotional intimidation or made to take part in sexual activity against your will)?

Name _____

Gynecological History

- ☐ Menarche (age at 1st period) _____
- ☐ Is your cycle regular? _____
- ☐ Cycle length (e.g. 28 days)_____
- ☐ Year of last PAP Smear _____
- ☐ Any abnormal PAP Smear? _____
  - ☐ If yes, when and what was abnormal?

    _____

- ☐ Fibroids
- ☐ Endometriosis
- ☐ Abnormal Bleeding
- ☐ Breast Lumps
- ☐ Infertility
- ☐ Cervicitis
- ☐ Cervical Polyp
- ☐ Ovarian Cyst
- ☐ PCOS
- ☐ Cervical Procedures:
  - ☐ Colposcopy
  - ☐ Cerclage
  - ☐ Biopsy
  - ☐ Cryotherapy
- ☐ Uterine Surgery
- ☐ D & C
- ☐ Breast Surgery

Infections

- ☐ Yeast
- ☐ Bacterial Vaginosis
- ☐ Group B Strep
- ☐ HPV (Human Papilloma Virus)
- ☐ Condyloma (warts)
- ☐ Genital Sores
- ☐ Herpes Simplex Virus
  - ☐ HSV1 (oral)
  - ☐ HSV2 (genital)
- ☐ Trichomonas
- ☐ Gardenerella
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ HIV / AIDS

Obstetrical History Please fill in information about all previous pregnancies.

Gravda	Para	Preterm	TOP	SAB	LC

#	Date of Delivery	Gestational Age (wks)	Sex	Name	Place of Delivery	Labor (hrs)	Induction?	Type of Delivery	Meds	Baby's Weight	Tear / Episiotomy
1											Sutured Y / N
2											Sutured Y / N
3											Sutured Y / N
4											Sutured Y / N
5											Sutured Y / N
6											Sutured Y / N
7											Sutured Y / N
8											Sutured Y / N
9											Sutured Y / N
10											Sutured Y / N

Notes: _____

_____

_____

_____

Name _____

Current Pregnancy

- ▫ Last Menstrual Period _____
- ▫ Was it normal length / flow? _____
- ▫ Last Normal Period _____
- ▫ Suspected Conception Date _____
- ▫ Date of Pregnancy Test _____
- ▫ Planned Pregnancy? _____
- ▫ Most recent birth control used _____
- ▫ History of problems with contraception _____
- ▫ Multiple sexual partners in the last 5 years _____

- ▫ Nausea
- ▫ Vomiting
- ▫ Fever
- ▫ Headaches
- ▫ Vaginal Bleeding / Spotting
- ▫ Vaginal Discharge
- ▫ Dizziness
- ▫ Headache
- ▫ Leg Cramps
- ▫ Rash
- ▫ Varicose Veins
- ▫ Hemorrhoids
- ▫ Backache
- ▫ Swelling
- ▫ Constipation Diarrhea
- ▫ Urinary Incontinence
- ▫ Abdominal / Pelvic Pain
- ▫ Loneliness
- ▫ Depression
- ▫ Family / Relationship Problems
- ▫ Work Problems

- ▫ Planned Place of Birth:
  - ▫ Home - Birth Center - Hospital
- ▫ Do you have previous breastfeeding experience?
  - ▫ Yes / No
- ▫ Do you plan to breastfeed?
  - ▫ Yes / No
- ▫ Have you ever taken a childbirth class?
  - ▫ Hypno - Birthing / Hypno - Babies
  - ▫ Bradley Method
  - ▫ Birth Matters
  - ▫ Birth Boot Camp
  - ▫ CMS - Birthing at Home
  - ▫ Lamaze
  - ▫ Other
- ▫ Do you plan to take classes this pregnancy?
  - ▫ Yes / No
- ▫ Special Diet? _____
- ▫ Supplements / Medications? _____
- ▫ Stress levels: High - Medium - Low

Assisted Fertility / Pregnancy (if applicable)

- ▫ Hormone Treatment
- ▫ IVF
- ▫ ICSI
- ▫ Intrauterine Insemination
- ▫ Egg donation
- ▫ Sperm donation
- ▫ Embryo donation
- ▫ Surrogacy

- ▫ How long had you been trying to conceive? _____
- ▫ Will you be continuing to see a fertility specialist? _____

Additional Questions

What are your feelings about this pregnancy? _____

_____

Your partner's feelings? _____

_____

Are there any particular ethnic, cultural, lifestyle or religious preferences you have for your pregnancy or birth you would like us to be aware of? _____

_____

Is there anything else you would like us to know about you, your lifestyle, or family dynamics? _____

_____

_____

Community Midwifery Services, LLC

Office: 405-447-9433
Fax: 405-703-9089

2121 W Main
Norman, OK 73069

Tax ID# 72-1550366

www.cmsmidwife.com
cmsmidwife@att.net

Client Name	
Client SSN	
Client Date of Birth	
Address	
City, State, Zip	
Primary Phone Number	
Secondary Phone Number	

Date	Description of Service	Charge	Credit	Balance

Payer Name	
Payer Address	
Payer Phone Number	

Community Midwifery Services Pager Instructions

405-558-8874

Contacting the Midwife on Call after Business Hours:

If you are in labor or have a true emergency, please listen to the voice prompt. It will tell you exactly what to do to reach the midwife on call. The on-call status can change throughout the day, so please check the pager prior to calling the midwife.

If it is not an emergency, leave a voice message after the tone and the midwife will call you back at her earliest convenience, usually between business hours. You must end the call by pressing the # button on the phone or we will not receive the page.

Call (do not text) your Midwife if you experience:

- Preterm Labor (before 37 weeks): 4 or more contractions in 1 hour. Preterm Labor can also present less obviously as a combination of symptoms such as: sudden onset of persistent low back pain, menstrual like cramps, pelvic pressure, or diarrhea.
- Bleeding: more than 1 tablespoon of bright red blood
- Anything you feel could be an immediate health risk for you or the baby
- Lack of fetal movement: If you have not felt movement in several hours, hydrate, have a snack and change your activity. Call the midwife if no change occurs.
- Early Labor: We always appreciate knowing things may be warming up! We encourage you to call us at any point you feel a need for support or have a question.
- Labor (5-1-1): We definitely should hear from you by the time your contractions are regular at 5 minutes apart (start of 1 contraction to the start of the next), and have been lasting 1 minute long for 1 hour or more. Fluid leaking or bloody show are also reasons to contact us even if contractions have not picked up yet.
- Labor (10-1-1): If you have had a precipitous labor in the past, it is a good idea for us to hear from you sooner such as when you contractions are 10 minutes apart (start of 1 contraction to the start of the next) and last a minute long.

For non-urgent inquiries during the week, please call the office (405-447-9433) before trying the pager. Our office hours are Tuesday through Thursday: 10am - 5pm.

Standards for Transfer of Care

Midwifery clients often ask under what circumstances they might need to transfer care to a physician or hospital based midwife. The following is a list that is derived from the home birth guidelines set by the Oklahoma Midwives Alliance and the American College of Nurse Midwives. Of course, as stated in the informed consent there are situations not listed that would be at the discretion of the birth attendant.

Prenatal conditions that contradict home birth:

- Premature labor (< 37 wks)
- Prolonged pregnancy with documented change in fetal status (> 42 wks)
- Polyhydramnios (excessive amniotic fluid)
- Oligohydramnios (inadequate amniotic fluid)
- Intrauterine growth restriction
- Placenta previa at term
- Marked maternal anemia at term
- Known or suspected fetal anomaly requiring immediate medical attention at birth
- Complications due to maternal smoking
- Substance Abuse

Special circumstances requiring hospital transfer in labor, birth and postpartum:

- Fetal heart rate persistently under 100 bpm or over 160 bpm
- Abnormal presentation or position of the baby
- Meconium stained amniotic fluid
- Frank bleeding
- Active herpes lesion during labor
- Prolonged labor without progress and or maternal exhaustion
- Elevated maternal temperature with ruptured membranes
- Cord prolapse
- Severe or persistent postpartum hemorrhage
- Retained placenta
- Newborn displaying abnormal signs or symptoms

I have read and understand the above information

Signature: _____ Date: _____