Women's Health Questionnaire

Last Name: | First Name: | Date:

REPRODUCTIVE HISTORY

How many pregnancies have you had?

How many births have you had?

Please explain if applicable:

Are you or have you used oral contraceptives or hormone treatments? Y N

If yes, please list & for how long?

What is the date of your last menstrual cycle?

Please list & explain any abnormal menses or concerns you have experienced (past & present):

MOST RECENT BIRTH

Please check the following for your most recent birth

- Third Trimester Presentation: Vertex / Breech / Transverse / Face/Brow / Posterior
- Type of Birth: Vaginal / Forceps / Vacuum / Cesarean (ER or planned?)
- Interventions: Medication / Epidural / Ruptured Membranes

Delivery Location:

OB/Midwife Name:

PREGNANCY & BIRTH STORIES

Please include all births, starting with your most recent birth.

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CURRENT PREGNANCY

How many weeks are you?

Guess Date:

Do you plan on birthing at:
- Home
- Birthing Center
- Hospital

If not birthing at home, please name birthing location:

Have you experienced any spotting or cramping? If yes please explain:

Do you plan on using a: (check all that apply)
- Doula
- Midwife
- Nurse Midwife
- OB

List all birth practitioners you are seeing:

Do you plan on breastfeeding?
- Y
- N

Do you plan on vaccinating this child?
- Y
- N
- Undecided

Are you planning on taking a pregnancy or birth education class?
- Y
- N

POSTPARTUM

Since giving birth have you or did you experience any of the following:
- Depression/Sadness
- Pelvic/Pubic pain
- Hip/Low back pain
- Unusual bleeding/Discharge
- Weakness/Fainting
- Breast feeding problems
- Constipation/Incontinence
- Diastasis recti (answer if you are 3+ months postpartum)
- Other

Explain any boxes checked above:

Please list any postpartum complications you have experienced:

Patient Signature

Date