**Prenatal Face Sheet**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_Race\_\_\_\_\_\_\_\_\_\_\_\_Marital Status\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_Zip Code\_\_\_\_\_\_\_

County of residence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s date of birth\_\_\_\_\_\_\_Number of pregnancies\_\_\_\_\_\_\_Number of living children\_\_\_\_\_

Miscarriages\_\_\_\_\_How far along were you with loss?\_\_\_\_\_\_\_\_Date of loss\_\_\_\_\_\_Abortions\_\_

Date of last period\_\_\_\_\_\_\_\_Forms of birth control\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Pap Smear\_\_\_\_\_\_\_\_\_\_\_\_ Ever had an abnormal Pap?\_\_\_\_\_\_\_When?\_\_\_\_\_Mom’s occupation (if outside the home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mom’s soc sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father’s soc sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father’s occupation

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father’s work or cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Church\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Drug allergies**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Herbal remedies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current and past medical conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history of:** Circle one Who?

Cancer yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TB yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childhood Illnesses**: Circle one If yes, give approximate date

Measles yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mumps yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chicken Pox yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whooping Cough yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Scarlet Fever yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Menstrual History**: **Who to contact in case of emergency**:

Age of onset\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are they regular? yes\_\_no\_\_varies\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does it last?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it light, medium or heavy?\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you normally pass clots?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain or cramping?\_\_\_\_\_\_\_\_\_\_\_

Are you currently having vaginal discharge?\_\_ Back-up physicians you wish to use:

If so, amount and color\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Gonorrhea, Chlamydia, Herpes, HIV **Mother’s Physician**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condyloma, Syphillis, etc?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature Verification (for midwife’s use)** Date of contact about home birth\_\_\_

Midwife’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials\_\_\_

Midwife’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials\_\_\_ **Baby’s Physician**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apprentice’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of contact about home birth\_\_

Homesteady Homebirth 2021