mandala midwifery

Esther Healey, CPM, LM
336 East 15th Street #3, Oakland, CA 94606
Esther@MandalaMidwifery.org
www.MandalaMidwifery.org
Work: (510) 479-0905
Fax: (888) 806-9078

Intake for Birth & Well-Woman Services

With the assurance of confidentiality, the following information is taken in order to provide you with the most holistic care possible. While any information given is appreciated and lends to the quality of care provided, it is always your right to skip a question. If there are choices provided to a question, you are welcome to simply circle the word as it applies to you. Please allow approximately an hour to fill out this form. Thank you.

You will need: Insurance card, basic information for your partner and/or the biological father, basic family medical history for you and the biological father, your vaccines card, and your past medical history.

Date	Date of Birth	Age	Medical Record #	
LMP *sure/unsure*	Conception *sure/unsure*	EDD *(Naegele's)*	EDD *(Wood's)*	Weeks Now *(Wheel)*
Gravida	Para	SAB/TAB	SB	Living
First	Middle	Maiden	Last	
Physical Address				
Mailing Address				
Home Phone		Cell Phone		
Email		E-mail *(Partner's/Father's)*		
Social Security #		Living Situation *(Marital Status)*		
Name *(Partner's/Father's)*		Phone *(Partner's/Father's)*		
Social Security # *(Partner's/Father's)*		Date of Birth *(Partner's/Father's)*		Blood Type *(Biological Father)*
Insurance Company		Insurance Plan		
Insurance ID #		Insurance Group #		
Emergency Contact Name & Relation *(Separate from partner; to make medical decisions.)*		Emergency Contact Phone #		

SOCIAL HISTORY:

Occupation	Occupation *(Partner's/Father's)*	
Hobbies and Creative Pursuits		
What is your home life like? *(With whom do you live, animals, do you feel safe?)*		
Religion/Spirituality	Race/Ethnicity	Race/Ethnicity *(Biological Father)*

GENERAL HEALTH HISTORY:

Allergies *(Drugs/Other)*	Sensitivities

Antibiotic Use
(General statement of use in lifetime)
(Use in the last 3 years)

Vaccinations/Immunizations & Year
(Feel free to attach a copy of your vaccinations card.)

Please check the types of medical care you have received in your lifetime:

❑ Conventional ❑ Acupuncture ❑ Naturopathic ❑ Homeopathic ❑ Therapy ❑ Other:

Previous Primary Care MD/OB/GYN	Previous Medical Care Provider

What is your experience with former care providers *(effectiveness)*? Any concerns?

❑ Check this box if you feel as though you experienced, from a care provider, abuse/violence/malpractice

Please check if you have had any of the following conditions or issues:

❑ Diabetes/Blood Sugar Imbalance	❑ Hypertension/Blood Pressure Issues	❑ Seizures/Nervous System Issues
❑ Heart Disease/Heart Issues	❑ Thyroid/Glandular/Endocrine Issues	❑ Kidney Disease/Kidney Issues
❑ Hepatitis/Liver Issues	❑ Asthma/Breathing/Sinus/Lung Issues	❑ Bladder Infection/Urinary Issues
❑ Skeletal/Bone Issues	❑ Pulmonary Embolism	❑ Swelling/Edema *(localized or general)*
❑ Concussion/Unconsciousness	❑ Hemorrhoids	❑ Hemorrhage/Blood Transfusion
❑ Headaches/Migraines	❑ Varicose Veins/Phlebitis	❑ Eye/Vision Issues
❑ Pelvis/Back/Spine Injuries/Issues	❑ Ear/Hearing Issues	❑ Glasses/Contacts
❑ Dental/Mouth/Gum/Jaw Issues	❑ Cancer	❑ Autoimmune/Immune Issues
❑ Piercings *(other than ears/face)*	❑ Generalized/Localized Pain *(current)*	❑ Significant Illness(es)
❑ Addictions	❑ Depression/Emotional/Mental Illness	❑ Accident(s)/Significant Injuries
❑ Rashes/Hives/Cysts/Sores/Warts/ Skin Issues	❑ Blood Clotting Issues/Anemia/ Blood Issues	❑ Arthritis/Joint/Muscular/Tendon Issues
❑ Stomach/Intestine/Digestive/ Bowel Issues	❑ Virus/Bacteria/Fungus/Parasite Infection/Issues	❑ Surgeries/Hospitalization(s)/ Significant Medical Procedures

Please provide information regarding the date when symptoms appeared, date of diagnosis, treatment, and any follow up received. Also describe any other conditions/concerns not on this list.

Please check any that apply:	❑ Are you and the baby's father related by blood?	❑ Have you had exposure to DES (Diethlstilbestrol) *(medication)*

What is your exposure to occupational or environmental hazards/strain/stress?

What is your history of smoking cigarettes? (*When, how long, often, amount?)* How is that for you now?

What is your history of using drugs and/or alcohol? (*How long,, when, often, amount?)* How is that for you now?

What is you history of concerns for your body image, weight, diet, etc? How is that for you now?

What is your history of bulimia, anorexia, or eating disorders? How is that for you now?

What is your history of experiencing sexual, emotional, or physical abuse, domestic violence or rape? How is that for you now?

Do you have any concerns regarding your safety?

What do you do for exercise? How often and how is that for you now?

What over-the-counter or prescribed medications are you taking?

What vitamins/herbs/natural remedies or supplements are you currently taking and for what reasons?

How would you describe your usual diet?

GENETIC/FAMILY HISTORY:

Please check if you, the baby's father, or anyone in either family have had any of the following conditions.
(Siblings, grandparents, aunts, uncles, cousins of your blood line.)

- ❑ Down Syndrome (Mongolism)
- ❑ Hemophilia *(bleeding disorder)*
- ❑ Cystic Fibrosis *(lung disease)*
- ❑ Tay-Sachs
- ❑ Muscular Dystrophy
- ❑ Neurofibromatosis
- ❑ Epilepsy
- ❑ Cleft Lip/Palate
- ❑ Phenylketonuria (PKU)
- ❑ Sickle Cell Disease/Thalassemia
- ❑ Heart Defect
- ❑ Abdominal Wall Defect
- ❑ Neural Tube Defect, Spina Bifida, Anencephaly
- ❑ Other birth anomalies, genetic disorders, congenital anomalies, nerve or muscle disorders, chromosomal abnormalities, blood anomalies, autoimmune diseases

Please provide information regarding any checked boxes.

Are there any hereditary diseases or conditions in either family such as diabetes, cancer, heart disease, hypertension, mental illness, TB, kidney disease, or allergies? *(Who, relation, reason, old age or lifestyle related?)*

GYNECOLOGICAL HISTORY:

Age of first menstruation	Days between menses *(Last 5 years)*	Duration of menses *(Last 5 years)*

Last Menstrual Period (LMP)	Was it normal?	# of days of last cycle (before LMP)

What do your menses look like? *(Quality, quantity, color, sensations, pain?)*

Was there a time when your menses seemed abnormal to you? If so, please describe.

Describe your relationship with your menses? *(Likes, dislikes, moods?)*

What types of products do you use with your menses? *(Sanitary pads, sponge, cup, tampon)*

Are you able to differentiate vaginal fluids that are normal from that of an infection?
(Quality, quantity, color, sensations?)

What is your history with douching?

Do you ever bleed/spot between periods?	Do you ever have hot flashes?

Do you know what ovulatory vaginal fluid looks/feels like?	Are you familiar with Fertility Awareness Method (FAM)?

Date of last PAP	Was it normal?

Have you ever had an abnormal PAP? Have you ever had a colposcopy, cervical or endometrial biopsies, cone biopsy, cryotherapy (freezing), laser treatment, LEEP (Loop Electrosurgical Excision Procedure)? If so, please provide details of when & what you did for followup.

Date of last Clinical Breast Exam	Was it normal?
Date of last Mammogram	Was it normal?

Have you ever had an abnormal breast exam? Have you ever had a breast tissue biopsy? If so, please provide details of when & what you did for followup.

Please check if you've ever had any of the following:

❑ Yeast Infection	❑ Abnormal Bleeding	❑ Endometriosis *(Cells of uterus grow outside)*
❑ UTI	❑ Cysts or Polyps *(Ovary, Cervix, Uterus)*	❑ Endometritis *(Inflammation)*
❑ Genital Sores	❑ Fibroids (Myomas)	❑ Cervicitis *(Inflammation)*
❑ Oral Herpes	❑ Infertility	❑ Pelvic Inflammatory Disease (PID)
❑ Swollen Bartholin Glands	❑ Breast/Nipple/Duct Issues/Masses/Surgery	❑ Uterine/Cervical/Tubal/Ovarian Pain/Surgery/Issues

❑ Sexually Transmitted Infections (STI's): Gonorrhea, Chlamydia, Gardnerella, Trichomonas, Syphilis, Condyloma *(warts),* Bacterial Vaginosis (BV), Human Papilloma Virus (HPV), Genital Herpes (HSV), HIV/AIDS

Please provide information regarding the date when symptoms appeared, date of diagnosis, treatment, and any follow up received. Please describe other reproductive conditions or issues not on this list.

SEXUAL HISTORY

Types of sexual relationships *(Male/Female)*	Number of current sexual relationships
Number of sexual partners *(Lifetime)* ❑ 0-6 ❑ >10 ❑ 6-10	How often do you have sexual relations each month? ❑ 0-1 ❑ 6-10 ❑ 2-5 ❑ >10
Has there been a struggle for you regarding your sexuality?	
Are there any sexual partners for whom you don't/didn't know they're STI status or who had a known STI? ❑ Yes ❑ No	Did/Do you have unprotected sex (oral or intercourse) with any of these partners with unknown status? ❑ Yes ❑ No
Do you feel comfortable asking your partner(s) to have STI testing before sexual relations? ❑ Yes ❑ No	Are you concerned you may have an STI? ❑ Yes ❑ No
What is your satisfaction with your sexual relationship(s). Are there any concerns/issues? (*Insufficient foreplay, insufficient lubrication, lack of consideration, pain, fears, unable to communicate?)* Do you have any problems specifically with your partner(s) *(Impotence, premature ejaculation, violence?)*	
What types of contraceptive methods have you used and when? *(Pill, condoms, shot, rod, IUD, FAM, withdrawal, etc.)* How have they worked for you? Any complications? For what reasons did you discontinue use?	
Would you like more information and/or options regarding birth control? ❑ Yes ❑ No	
What is your history with hormone replacement therapy? Please provide details.	
Have you used fertility medications?	

PREGNANCY HISTORY:

Please list information about any *previous* pregnancies:

Name	Date of Birth	Sex	Weeks Gestation	Type of Birth *(Vaginal, C-Section)*	Length of Labor	Birth Weight	Place of Birth	Notes/complications? *(miscarriage, abortion, stillbirth)*
1)								
2)								
3)								

Please describe any pertinent information, complications, your understanding of any interventions, and your experience as a whole.

What was your experience with breastfeeding? *Did you breastfeed? For how long? With whom? Complications?*

Have you ever had the following with your ***previous*** pregnancies and/or labors?

❑ Placenta Previa	❑ Uterine Infection	❑ Uncontrollable Hemorrhage
❑ Breech Presentation/External Version	❑ Pre Eclampsia/Eclampsia	❑ Retained Placenta
❑ GBS+	❑ Ultrasound	❑ Premature Labor
❑ Anemia	❑ Inverted Uterus	❑ Assisted Birth *(Forceps/Vacuum)*
❑ Rupture of Waters w/o Labor	❑ RH Sensitized/RhoGAM	❑ Contractions w/o Dilation
❑ Gestational Diabetes/ Blood Sugar Imbalance	❑ Pregnancy Induced Hypertension (PIH)	❑ Medical Induction/Labor Stimulation *(Pitocin, Cervidil, Misoprostol)*
❑ Depression/Postpartum Depression	❑ Cervical Tearing/Laceration	❑ Perineal/Labial Tearing/ Episiotomy/Suturing

Please provide details regarding any checked boxes

Please check if you have had any following related to ***this*** pregnancy:

❑ Bleeding:	❑ Heartburn/Indigestion:
❑ Visual Disturbances:	❑ Constipation/Diarrhea:
❑ Dizziness:	❑ Hemorrhoids:
❑ Headaches:	❑ Varicose Veins:
❑ Swelling:	❑ Leg/Foot Cramps:
❑ Unusual Appetite:	❑ Abdominal Cramping:
❑ Unusual Cravings:	❑ Poor/Irregular Sleep Habits:
❑ Nausea/Vomiting: *(When?)*	❑ X-Ray/CT Scan Exposure *(When?)*
❑ Genetic Screening: *(When?)*	❑ Ultrasound: *(When?)*

Notes or Additional Comments:

Completed By: