Client History

Thank you for taking the time to complete our paperwork. We acknowledge that it will take a bit of time — so sit down, pour yourself a cup of tea, and pull out your favorite pen! The information you provide will help us get to know you and individualize your care. Please complete prior to your first appointment.

Demographics

Your Full Name

Date of Birth | Age

Address

City | State | Zip

Mobile Number | Home Number

Email | Social Security Number

Race/Ethnicity | Primary Language

Marital Status ☐ Married ☐ Partnered ☐ Single ☐ Widowed

Spouse/Partner Name | Spouse/Partner Phone Number

Identified Gender Pronouns

Emergency Contact Person | Emergency Contact Phone Number

Employer | Type of Work

Work Phone Number

Insurance

Primary Insurance

Billing Address

Phone Number | Policy Number | Group Number

Policy Holder's Name | Date of Birth

Secondary Insurance

Billing Address

Phone Number | Policy Number | Group Number

Policy Holder's Name | Date of Birth

Authorization to provide medical information via:

Phone Number | Email

Authorization to provide medical information to

Signature

Boulder Community Health
THE BIRTH CENTER OF BOULDER

2800 Folsom Street, Boulder, CO 80304
303-443-3993 • bch.org/bcob

What brought you to the birth center?

How did you hear about us ☐ Friend ☐ Referral ☐ Google ☐ Other

Client history

Height Pre-pregnancy Weight

Pregnancy

How are you feeling about this pregnancy?

Was this pregnancy planned? ☐ Yes ☐ No

What are your hopes for this pregnancy?

What are your biggest fears about pregnancy, birth, and parenting?

Do you have any cultural/religious beliefs about pregnancy/birth that you want supported?

Who is the co-parent of the baby? Age

Occupation

Do you live together? ☐ Yes ☐ No If yes, for how long?

Level of involvement in the pregnancy: ☐ Very ☐ Somewhat ☐ Not at all.

Does your partner have any other children? ☐ Yes ☐ No

How do you feel about your relationship?

How does your partner feel about this pregnancy?

Social history

Your level of education ☐ High School ☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

What is your occupation? If you are now staying home with your children, what work did you do previously?

How much do you work? ☐ Full Time ☐ Part Time ☐ Days ☐ Nights

Do you plan to return to work or school after your baby is born? ☐ Yes ☐ No

If yes, when? How many hours per week?

Who can you count on for support during your pregnancy, labor, birth, and postpartum?
☐ Partner ☐ Family ☐ Friends ☐ School ☐ Co-Workers ☐ Neighbors ☐ Others

Do you feel connected to/supported by your community? ☐ Yes ☐ No

Are you planning to take childbirth preparation classes, or have you previously taken any? ☐ Yes ☐ No

If yes, what classes have you taken or plan to take?

My partner will attend/has attended classes with me ☐ Yes ☐ No

What kind of relationship do you have?

- ☐ New relationship.
- ☐ Long-term relationship with one partner.
- ☐ More than one partner in past year.
- ☐ No current partner.

How safe do you feel in your home?

- ☐ Very safe. No concerns with domestic violence.
- ☐ Safe now, but have had concerns with domestic violence in the past.
- ☐ I do not feel safe at home.

Have you ever or are you currently feeling abused physically, emotionally, sexually, or financially?

- ☐ Never.
- ☐ I have felt abused in the past but not currently.
- ☐ Yes, I am currently feeling abused.

1 in 3 women have been sexually assaulted in their lifetimes. These traumas can impact how we feel about pregnancy and influence our labor and birthing process in unexpected ways. If you have experienced sexual assault, are you interested in a recommendation for a therapist? ☐ Yes ☐ No

Activity/rest

How often do you exercise? ☐ None ☐ Daily ☐ 3-5 days/week ☐ 1-2 days/week

Do you have any physical limitations? ☐ Yes ☐ No

What types of exercise do you enjoy?

How many hours of sleep do you get per night? ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10+

Do you have any trouble sleeping? ☐ Yes ☐ No

If yes, please elaborate:

Caffeine, alcohol and drugs

How many 8 oz. servings of caffeine do you drink per day? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4+

What kind? ☐ Coffee ☐ Tea ☐ Soda

How many alcoholic drinks have you had per week over the past 3 months? None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

What kind? ☐ Wine ☐ Beer ☐ Liquor

Has anyone close to you complained about your drinking in the past year? ☐ Yes ☐ No

Do the drinking habits of anyone in your household worry you? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ Never

If yes, in the past. When did you quit and how much did you smoke?

If yes, currently. How many cigarettes per day? Do you want to quit? ☐ Yes ☐ No

Have you ever used the following drugs: Marijuana, Cocaine, LSD, Heroine, Methamphetamines, Ecstasy?

- ☐ Never
- ☐ In past. What type and how much/how often?
- ☐ Currently. What type and how much/how often?

Does anyone in your household use drugs? ☐ Yes ☐ No

If yes, what type and how much/how often?

Do you take prescription pain medications? ☐ Yes ☐ No

If yes, what type and how much/how often?

Resource/needs assessment

What type of housing do you currently live in? ☐ Home ☐ Apartment/Condo ☐ Trailer

Do you feel it is adequate for your needs? ☐ Yes ☐ No

Do you receive food program assistance (WIC or food stamps)? ☐ Yes ☐ No

How often do you use a seatbelt when driving? ☐ Always ☐ Often ☐ Never

Do you have difficulty with reading, seeing, hearing, or following instructions? ☐ Yes ☐ No

Do you have other needs you need help with? ☐ Yes ☐ No

If yes, please elaborate:

Nutritional history

Do you follow any special diet? ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Paleo ☐ No ☐ Other

If other, please specify

Do you have any food allergies or intolerances? ☐ Yes ☐ No

If yes, please specify

How many times do you eat per day? Meals Snacks

Please recall your diet over the last three days to calculate your protein intake.

How many servings of protein per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

What types of protein? ☐ Meat ☐ Eggs ☐ Beans ☐ Tofu ☐ Nuts

Do you feel like you eat a well balanced diet? ☐ Yes ☐ No

Recommendation for adequate fluid intake is 4-6 liters per day. How many liters of fluid do you drink a day?

Have you eaten or had cravings for any of the following: dirt/clay, laundry starch, corn starch, baking soda, plaster, refrigerator ice? ☐ Yes ☐ No

We will review your BMI and diet recommendations and weight gain goals at your appointment.

Low BMI: 28-40 pound weight gain
Normal BMI: 25-35 pounds weight gain
High BMI: 15-25 pounds weight gain

Gynecological history

When was the first day of your last menstrual period?

This date is: ☐ Certain ☐ Week ☐ Known ☐ Guess

That period was ☐ Normal ☐ Lighter ☐ Earlier ☐ Later

Do you know when you conceived?

When did you get a positive Home Pregnancy Test?

How old were you got your first period?

How regular are your cycles? ☐ <28 days ☐ 28-30 days ☐ >30 days ☐ Irregular

Duration of flow? ☐ 2-3 days ☐ 3-5 days ☐ 5-7 days

Amount? ☐ Heavy ☐ Normal ☐ Light

Character? ☐ Painless ☐ Clots ☐ Cramping ☐ Other:

Do you experience PMS symptoms? ☐ Yes ☐ No

If yes, describe

Who do you have sex with? ☐ Men only ☐ Men and Women ☐ Women only

Are you satisfied with sex? ☐ Yes ☐ No: elaborate

Do you experience any pain with sex? ☐ Yes ☐ No

When was the date of your last pap? Was it normal? ☐ Yes ☐ No

Please complete a release of records for your last pap for our records.

If age > 40, have you had a baseline mammogram or thermogram? ☐ Yes ☐ No

Have you received the Gardasil (HPV) vaccine? ☐ Yes ☐ No

Pregnancy history

Tell us more about this pregnancy, specifically conception:

☐ Intercourse ☐ IUI ☐ IVF ☐ Surrogacy ☐ Embryo Transfer
☐ Donor Egg ☐ My Egg ☐ Partner Sperm ☐ Donor Sperm

Total Pregnancies (including current): Full Term Births: Preterm Births:

Twin/Multiple Births: Ectopic Pregnancies: Miscarriages:

Therapeutic or Induced Abortions: Living Children:

List All Pregnancies from first to last, including miscarriages or abortions:

Date	# Weeks	Type of Birth	Gender	Hours of Labor	Weight	Place of Birth	Pain Management	Child's Name

Were you happy with your birth experience(s)? ☐ Yes ☐ No

Did you have any complications with any pregnancy, birth, or postpartum? ☐ Yes ☐ No

If yes, please elaborate:

Did any of your babies have any problems after birth, and do any of them have health issues now? ☐ Yes ☐ No

If yes, please elaborate:

How do you plan to feed your baby? ☐ Breast ☐ Bottle ☐ Both

If breastfeeding, for how long? ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ >12 months

If you have breastfed before, did you experience any problems?

Contraception

What birth control have you used in the past? For how long? Were you satisfied with the method?

☐ Oral Contraceptives	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ Condoms	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ Withdrawal	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ Natural Family Planning	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ ParaGard	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ Mirena/Skyla/Kylee	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ Diaphragm/Cervical Cap	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ DepoProvera	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ NuvaRing	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ Nexplanon/Implanon	For how long?	Satisfied with method?	☐ Yes	☐ No
☐ Vasectomy	For how long?	Satisfied with method?	☐ Yes	☐ No

☐ N/A: Same Sex Relationship

Gynecologic disorders

Note the date(s) that you had any of the following.

☐ I Have No History of Gynecological Problems
☐ Abnormal Mammogram
☐ Abnormal Paps
☐ Cryo / LEEP / Conization of the Cervix
☐ Endometriosis
☐ Fibroids
☐ Genital Warts
☐ Genital Herpes
☐ Gonorrhea or Chlamydia
☐ Infertility
☐ Ovarian Cysts
☐ Pelvic Inflammatory Disease
☐ Trichomoniasis or Syphilis
☐ Uterine Abnormalitis
☐ Vaginal Infections: Yeast, Bacterial Vaginosis
☐ Other

"Does your current partner have genital herpes? ☐ Yes ☐ No

Medical history

Date of last Tetanus/Diptheria/Pertussis (TDAP) booster:

Date of last Flu shot:

Have you been vaccinated for Covid-19? ☐ Yes ☐ No

If yes: Brand received Date of most recent dose/booster

Has your partner been vaccinated for Covid-19? ☐ Yes ☐ No

If yes: Brand received Date of most recent dose/booster

Did you have Chicken Pox as a child or have you received the vaccine? ☐ Had illness ☐ Vaccinated ☐ Neither

Do you have cats? ☐ Yes ☐ No

If yes, do you change the litter box? ☐ Yes ☐ No

When was your last visit to the dentist?

Have you had any viral illnesses or fevers since becoming pregnant? ☐ Yes ☐ No

If yes, please elaborate:

Have you traveled internationally in the past 6 months? ☐ Yes ☐ No If yes, where?

Allergies

Please list any allergies you have (medications, iodine, shellfish, tape, and seasonal allergies) and the reaction.

☐ I Have No Known Drug Allergies

Personal history

Please indicate dates of applicable items.

☐ I Have No Personal History of Medical Problems
☐ Anemia
☐ Anxiety/Depression/Mental Illness
☐ Postpartum Anxiety/Depression
☐ Autoimmune Disorders: Lupus, MS
☐ Bleeding Disorders
☐ Blood Clots
☐ Cancer
☐ Diabetes: Type 1, 2, or Gestational
☐ Eating Disorder: Anorexia, Bulimia
☐ Headaches/Migraines
☐ Heart Disease
☐ High Blood Pressure: Chronic or in Pregnancy
☐ Intestinal Disease: Crohns, IBS
☐ Kidney or Bladder Infections
☐ Liver Disease: Hepatitis
☐ Lung Disease: Asthma, Tuberculosis, Pneumonia
☐ Periodontal Disease
☐ Rh negative blood type
☐ Seizures
☐ Thyroid Dysfunction
☐ Varicose Veins
☐ Other

Supplements or herbs

Please list all supplements/herbs you are taking, brand and dosage.

☐ I am not taking any supplements or herbs

Medications

Please list all medications / dosage / reason and for how long you have been taking.

☐ I am not taking any medications

Hospitalization and surgical history

List all past hospitalizations/surgeries other than childbirth: Dates, Reason, Complications

☐ I have not had any past hospitalizations or surgeries

Have you ever had any complications with anesthesia? ☐ Yes ☐ No

If yes, please list.

Have you ever received a blood transfusion? ☐ Yes ☐ No

If yes, when and why?

In the event of an emergency would you accept blood products? ☐ Yes ☐ No

Do you have an Advanced Directive on file? ☐ Yes ☐ No

Do you have a Power of Attorney on file? ☐ Yes ☐ No

Would you like more information on Advanced Directives and/or Power of Attorney? ☐ Yes ☐ No

Family medical history

Mother: ☐ Living. How is her health?

☐ Deceased. Age and cause of death

Father: ☐ Living. How is his health?

☐ Deceased. Age and cause of death

Number of sisters living	How is their health?
Number of sisters deceased	Age(s) and cause of death
Number of brothers living	How is their health?
Number of brothers deceased	Age(s) and cause of death

Does anyone in your family have a history of the following? List relation.

- ☐ No Family History of Medical Problems
- ☐ Cancer
- ☐ Anxiety/Depression/Mental Illness
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hepatitis/ Liver Disease
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Other

Does anyone in your family or the father of the baby's family have any of the following? If yes, list relation.

- ☐ Negative Family and Father of Child Family History
- ☐ Down's Syndrome
- ☐ Turner's Syndrome
- ☐ Tay Sachs
- ☐ Canavan
- ☐ Congenital Heart Defects
- ☐ Muscular Dystrophy
- ☐ Cystic Fibrosis
- ☐ Sickle Cell Trait
- ☐ Hemophilia
- ☐ Neural Tube Defects
- ☐ Mental Deficits
- ☐ Born prior to 37 weeks gestation
- ☐ Other genetic or chromosomal disorder?

Hereditary cancers

Please download and complete the Natera cancer screening questionnaire on bch.org/bcob.

Current health concerns. Review of systems.

Consider how you are feeling TODAY. If you are not experiencing any of the symptoms below, please initial the negative box.

General:

☐ Negative = no recent change in health or weight, fever, headaches, fatigue, weakness.

Head, eyes, ears, nose, and throat:

☐ Negative = no vision changes, hearing loss, allergies, nosebleeds, sore throat.

Breast:

☐ Negative = no breast lump or pain, tenderness, nipple discharge.

Cardiac:

☐ Negative = no chest pain, palpitations, varicose veins.

Respiratory:

☐ Negative = Denies chronic cough, coughing up blood, shortness of breath.

Gastrointestinal:

☐ Negative = Denies heartburn, nausea/vomiting, constipation, abdominal or pelvic pain.

Genitourinary:

☐ Negative = Denies painful urination, vaginal bleeding or discharge, painful sex.

Musculoskeletal:

☐ Negative = Denies joint swelling, muscle pain, leg pain or cramping, swelling, back pain.

Integumentary:

☐ Negative = Denies skin rash or itching, dry skin, moles, change in skin color.

Neurological:

☐ Negative = Denies dizziness, light headed, seizures, numbness, paralysis, vision changes.

Psychiatric:

☐ Negative = Denies anxiety, depression, memory loss, difficulty sleeping.

Endocrine:

☐ Negative = Denies excess thirst or urination, heat or cold intolerance.

Hematologic/ Lymphatic:

☐ Negative = Denies bleeding or bruising tendency, anemia, enlarged glands.

Primary care and alternative therapies

Who is your primary care physician? Phone Number

When was your last physical exam?

Who is your children's pediatrician? ☐ N/A or

Acupuncturist

Chiropractor

Massage Therapist

Physical Therapist

Psychotherapist

Other Practitioner

Signature

My signature confirms that the information provided is correct as far as I know.

Signature: Date

Thank you for taking the time to share with us your history.

Please remember to complete a HIPAA release of medical information form on bch.org/bcob.

Please review all consents on bch.org/bcob prior to your first appointment.

For office staff only

Client History Reviewed by: Date

Release of Records completed for: