

History of Birth

Date: ___/___/___ Name of Child: _____ Date of Birth: ___/___/___

LABOR AND DELIVERY:

What was your first sign of labor? _____

How long was the labor from the first regular contraction to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours/minutes

	Yes	No	
Hospital birth	<input type="checkbox"/>	<input type="checkbox"/>	

Name of Hospital: _____

Physician/Midwife: _____

Home birth	<input type="checkbox"/>	<input type="checkbox"/>	
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Midwife: _____

Birth Center birth	<input type="checkbox"/>	<input type="checkbox"/>	
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Name of Birth Center: _____

Physician/Midwife: _____

Vaginal Delivery	<input type="checkbox"/>	<input type="checkbox"/>	
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Planned C-section	<input type="checkbox"/>	<input type="checkbox"/>	If yes, why? _____
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Emergency C-section	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Was Birth Induced	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Pitocin:	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Breaking bag of waters:	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Suppository:	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Forceps delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Vacuum extraction	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Anesthesia administered	<input type="checkbox"/>	<input type="checkbox"/>	_____
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At what point during labor was anesthesia administered? _____

What type of anesthesia was used? _____

Fetal distress	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Meconium staining	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Episiotomy/Tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Head presentation	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Face presentation	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Breech presentation	<input type="checkbox"/>	<input type="checkbox"/>	_____
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BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

APGAR Scores: At 1 minute ___/10 At 5 minutes ___/10

Baby's Crying: Baby Cried Immediately After Birth Cried Strongly Weak Cry

Baby Did Not Cry for ___ minutes

Baby's Color: Pink all over Blue face Blue Hands/Feet Jaundice

Baby's Head: Bruised Swollen Red Misshapen

Baby's Activity: Arms and legs actively moving Floppy baby

Signs of Trauma: Yes No

Intensive Care: Was required Days in Neonatal Intensive Care Unit _____

Medication given at birth (to baby): _____

(to mom): _____

Vaccines administered: _____ Vitamin K Circumcision

Tests run: _____

Birth weight: ___ lbs. ___ oz. Birth length: ___ in.

Baby home on day _____ Mom home on day _____

Breastfeeding: Latched on right away Difficulty feeding Didn't Breastfeed