

## LABOR PREFERENCES

**W**e want to be able to meet your needs during your birth experience. Please use this sheet to help organize your thoughts about your individual preferences. Take your time, be creative and remember this is a guideline and it may change as your needs change. When you come to the hospital, please bring this with you to share with the labor nurse.

1. Your Name \_\_\_\_\_
2. Who will be your support person(s) in labor? \_\_\_\_\_
3. Did you attend any prenatal classes:  Yes  No

If yes, please list the names of the classes and where you attended the classes:

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If you are interested in taking any prenatal classes or any classes after the baby is born, please contact Perinatal Health Education at (626) 397-8768.

4. To encourage relaxation and help with labor discomfort would you like to use any of the following tools?

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|---|---|---|
| <input type="checkbox"/> Focal point, imagery | <input type="checkbox"/> Positioning in bed | <input type="checkbox"/> Massage (by partner) |
| <input type="checkbox"/> Music                | <input type="checkbox"/> Use birthing ball  | <input type="checkbox"/> Ambulation           |
| <input type="checkbox"/> Walking at bedside   | <input type="checkbox"/> Medication         | <input type="checkbox"/> Showering            |
| <input type="checkbox"/> Sitting in a chair   | <input type="checkbox"/> Epidural           | <input type="checkbox"/>                      |

5. What do you plan to bring from home to make your labor more comfortable

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Focal point                      | <input type="checkbox"/> Cotton Socks          | <input type="checkbox"/> Lotion (no or mild scent) |
| <input type="checkbox"/> Mouthwash or breath spray        | <input type="checkbox"/> Chapstick or lip balm | <input type="checkbox"/> Hand fan, spray bottle    |
| <input type="checkbox"/> Tapes/CDs to play for relaxation | <input type="checkbox"/> Other                 | <input type="checkbox"/> Other                     |

6. Are there any health issues, problems with your pregnancy or particular fears or concerns you would like to share with us?

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7. Have you selected your pediatrician?  Yes  No

Is he/she on your insurance plan  Yes  No

Does he/she have staff privileges at Huntington Hospital?  Yes  No

What is the pediatrician's name? \_\_\_\_\_

8. Will you be breastfeeding or bottle feeding the baby? \_\_\_\_\_

9. Do you have any special requests regarding your baby's care while in the hospital?

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