

Pregnancy History

Today's Date _____

Name _____ Sex: M F Date of Birth _____ Age _____

Mother's Name: _____ How many children do you have? _____

What was the term of your pregnancy? _____ weeks

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	Yes	No	
Falls	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motor Vehicle Accidents	<input type="checkbox"/>	<input type="checkbox"/>	_____
Near-miss MVA	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Morning sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other Illnesses	<input type="checkbox"/>	<input type="checkbox"/>	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

	Yes	No	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-prescribed drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>	Medication _____ Reason _____
Over-the-counter meds	<input type="checkbox"/>	<input type="checkbox"/>	Medication _____ Reason _____