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	❑	❑	______________________
Motor Vehicle Accidents	❑	❑	______________________
Near-miss MVA	❑	❑	______________________
High blood pressure	❑	❑	______________________
Diabetes	❑	❑	______________________
Anemia	❑	❑	______________________
Morning sickness	❑	❑	______________________
Indigestion	❑	❑	______________________
Seizures	❑	❑	______________________
Swollen Ankles	❑	❑	______________________
Thyroid problems	❑	❑	______________________
Heart problems	❑	❑	______________________
Back pain	❑	❑	______________________
Abnormal bleeding	❑	❑	______________________
Were you hospitalized	❑	❑	______________________
Any other Illnesses	❑	❑	______________________

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

	Yes	No	
Tobacco	❑	❑	______________________
Alcohol	❑	❑	______________________
Non-prescribed drugs	❑	❑	______________________
Prescription medications	❑	❑	Medication __________ Reason __________
Over-the-counter meds	❑	❑	Medication __________ Reason __________