PREGNANCY HISTORY

Today's Date ______________

Child's 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 B.P?	☐	☐	____________________
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 ______________

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