PREGNANCY HISTORY

Name: _____ Date: _____

How many children do you have?_____Age(s) _____

Term of your most-recent pregnancy? _____ wks

DURING YOUR PREGNANCY HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO	
Falls	❑	❑	If *YES*, Describe: _____
Motor Vehicle Accident (MVA)	❑	❑	If *YES*, Describe: _____
Near-miss MVA	❑	❑	If *YES*, Describe: _____
High Blood Pressure	❑	❑	If *YES*, Describe: _____
Diabetes	❑	❑	If *YES*, Describe: _____
Anemia	❑	❑	If *YES*, Describe: _____
Morning Sickness	❑	❑	If *YES*, Describe: _____
Indigestion	❑	❑	If *YES*, Describe: _____
Seizures	❑	❑	If *YES*, Describe: _____
Swollen Ankles	❑	❑	If *YES*, Describe: _____
Thyroid Problems	❑	❑	If *YES*, Describe: _____
Heart Problems	❑	❑	If *YES*, Describe: _____
Back Pain	❑	❑	If *YES*, Describe: _____
Abnormal Bleeding	❑	❑	If *YES*, Describe: _____
Were You Hospitalized	❑	❑	If *YES*, Describe: _____
Any Other Illnesses	❑	❑	If *YES*, Describe: _____
Previous Miscarriage(s)	❑	❑	If *YES*, Describe: _____

DURING YOUR PREGNANCY HAVE YOU USED ANY OF THE FOLLOWING:

Tobacco	❑	❑	If *YES*, Describe: _____
Alcohol	❑	❑	If *YES*, Describe: _____
Non-Prescribed Drugs	❑	❑	If *YES*, Describe: _____
Prescription Medicine	❑	❑	Medication: _____ Reason:_____
Over The Counter Meds	❑	❑	Medication: _____ Reason:_____