

# 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?	<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 B.P.?	<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 _____