

Pregnancy History

Name _____ Today's Date: _____

Pregnancy Questions:

Your Due date: _____ No of Weeks along: _____

Present complaint: _____

When did you first notice your problem? _____

Anything make it better? _____

Anything make it worse? _____

During your pregnancy have you experienced any of the following?

Falls	Yes	NO	_____
Motor Vehicle Accident (MVA)	Yes	NO	_____
Near Miss MVA	Yes	NO	_____
High BP	Yes	NO	_____
Diabetes	Yes	NO	_____
Anemia	Yes	NO	_____
Morning Sickness	Yes	NO	_____
Indigestion	Yes	NO	_____
Seizures	Yes	NO	_____
Swollen ankles / hands	Yes	NO	_____
Thyroid problems	Yes	NO	_____
Heart problems	Yes	NO	_____
Back pain	Yes	NO	_____
Abnormal bleeding	Yes	NO	_____
Have you been hospitalized	Yes	NO	_____
Any other illnesses	Yes	NO	_____

During your pregnancy did you use any of the following?

Tobacco	Yes	NO	_____
Alcohol	Yes	NO	_____
Prescribed Medications	Yes	NO	_____
Over the counter Meds	Yes	NO	_____

Medications taken within the last 3 months:

Name of Medications: _____

Dosage: _____

Reason for taking: _____

Results: _____

Are you happy with the results? Yes / No

Pregnancy Release

This is to certify that to the best of my knowledge I am pregnant and the above doctor and his/her associates have my permission to not perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

(Signature)

(Date)