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Pregnancy Intake

Name: _____

Date of Birth & Current Age: _____ Height & Weight: _____

What brings you in today? _____
_____

How far into your pregnancy are you? _____ Due date: _____

When was your last appointment with your doctor/midwife: _____

Blood pressure:

MEDICAL HISTORY
Are you presently taking any medications? If so, what?
_____
_____

Are you presently taking any vitamins/supplements? If so, what?
_____
_____

List any known allergies:

List any previous surgery or hospitalizations and the date/s:
_____
_____
_____
_____

Please indicate if you have had any of the following: C = Current / P = Past
___ Phlebitis, embolus, blood clots ___ Liver disease ___ Diabetes

___ Asthma or lung problems ___ Mononucleosis ___ Migraine
___ Depression/other psych problems ___ Kidney/bladder problems ___ Hepatitis
___ Varicose veins ___ High blood pressure ___ Jaundice
___ Thyroid problems ___ Breast problems ___ HIV
___ Weight problems ___ Acne ___ Cancer
___ Anemia ___ Skin Problems ___ Pacemaker
___ Alcoholism ___ Seizure Disorder ___ Other
Other: Please explain

FAMILY HISTORY Age/s Health Issues
Father _____
Mother _____
Sisters _____
Brothers _____
Paternal Grandparents _____
Maternal Grandparents _____

Do you exercise regularly? [ ] Yes [ ] No If yes, what and how often: _____
_____

Do you have a special diet now or in the past (vegetarian, vegan, Atkins, etc.)
_____

Please describe your daily meals:
Breakfast
_____
Lunch
_____
Dinner
_____

How much per day do you use of the following?
Coffee, tea, soft drinks:
_____
Alcohol:
_____
Cigarettes, cigars, other tobacco:
_____
Other drugs:
_____

Have you been treated for emotional issues? [ ] Yes [ ] No

Please list and briefly describe the most significant events in your life:
1. _____
2. _____
3. _____

4. _____

Date of last pap smear: _____ Mammogram: _____
Have you ever had a cervical biopsy, LEEP and/or cauterization? [ ] Yes [ ] No
Do you get yeast infections regularly? [ ] Yes [ ] No
Do you get bladder infections (UTI's) regularly? [ ] Yes [ ] No

Have you ever been diagnosed with: **(circle** all that apply)

Uterine fibroids Polyps Pelvic adhesions Prolapsed uterus

Pelvic abnormalities Endometriosis PCOS

OBSTETRICS
How long did it take for you to conceive?
_____
Have you ever been pregnant before? [ ] Yes [ ] No
Number of live births _____
Names & Ages
_____
_____

Number of abortions or miscarriages _____
Dates of miscarriages / abortions:
_____
_____
Where there any problems during or after these pregnancies?

Are you using a doula? [ ] Yes [ ] No Doula's name & phone: _____

Where are you planning on giving birth? _____
What prenatal classes are you taking or planning to take?
_____
Who would you describe as your primary source of support?
_____

Are you experiencing any nausea? [ ] Yes [ ] No

Are you experiencing any body pain? [ ] Yes [ ] No Where?
Mark areas of concern:

May we contact you in 6 months to see how you are doing? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:

Thank you for taking the time to complete this form.