SUPPLEMENTAL HISTORY FORM FOR PREGNANCY

Name:_______________________________ Date:____________________

Date of Birth:_________________________ Age:_____________________

Current History

Who is your prenatal caregiver? Midwife_____ Obstetrician_____

Where are you planning to give birth? Grand River Hospital_____ Home_____ Other_____

What is your due date?_________________ How many weeks are you now?____________________

Is this your: First_____ Second_____ Third +_____ pregnancy?

Have you had any of the following symptoms during pregnancy?

☐ Pelvic pain ☐ Pelvic pressure ☐ High blood pressure

☐ Vaginal Bleeding ☐ Pubic joint pain ☐ Rib pain

Other:____

Have you had any Ultrasounds? No_____ Yes_____ Dates:______________________________________

Past Health History

Have you had any previous miscarriages? No_____ Yes_____

Date and reason (if known)____

Did you have any difficulty conceiving? No_____ Yes_____

Did you have any complications with previous pregnancies? No previous pregnancies_____

☐ Hypertension ☐ Gestational diabetes ☐ Breech baby ☐ Back pain

Other:____

Did you have any complications with previous deliveries? No previous deliveries_____

☐ C-section ☐ Epidural used ☐ Forceps used ☐ Vacuum extraction used

Other:____

Before pregnancy, was your menstrual cycle regular? Regular_____ Irregular_____

Did you have any of the following menstrual symptoms?

☐ Heavy flow ☐ Abdominal bloating ☐ PMS ☐ Mild cramps

☐ Severe cramps ☐ Endometriosis ☐ Low back pain

Other:____