

Pregnancy Questionnaire

Is this your first pregnancy? Yes No If no, please tell us about your first pregnancy: _____

Do you plan to follow the same as your previous delivery? Yes No If no, please tell us about your first pregnancy:

CONCEPTION AND EARLY PREGNANCY

When is your expected or calculated due date? _____

Did you have any difficulty conceiving? Yes No If yes, please explain: _____

Have you ever used hormonal or oral contraceptive? Yes No

When was your last menstrual cycle? _____ What was your pre-pregnancy weight? _____

Have you experience morning sickness? Yes No If yes, please explain: _____

What type of exercise(s) are you currently performing? _____

Have you had any slips, falls or other physical trauma during the pregnancy? Yes No
If yes, please explain: _____

YOUR BIRTH PLAN

Your top three goals for this pregnancy:

- 1. _____
- 2. _____
- 3. _____

Do you currently have a birth plan? Yes No If yes, please explain: _____

Are you currently taking any pre-natal or birthing class? Yes No If yes, please explain: _____

Who is your OB/GYN or midwife? _____

Will you have birthing support present? (i.e. Doula, birth coach, midwife, etc.) Yes No
If yes, please explain: _____

Who is your birth provider? _____

Do you wish to have a natural vaginal labor and delivery? Yes No If no, what concerns do you have?
