PREGNANCY HISTORY

Patient Name: ____________________
Exam Date:_______________________ File # _______________________

Did/Do you have a written Birth Plan? _____________

Did/Do you receive prenatal care from an Ob/Gyn, Midwife or both?
____

Was/Is this a planned pregnancy? ______

Did/do you plan on breast feeding? _______ How long? _________

Pregnancy term (40 weeks) _________

Gestation Date ________________

Delivery Venue (hospital, birthing center, home) _________________________________
Type of delivery: Vaginal/Cesarean section.

Were any instruments used in delivery? Forceps/Vacuum/Other ____________________

____

During your pregnancy did/have you experience (d) any body pains? ________________
____

During your pregnancy did/have you receive (d) any medical diagnosis? ______________
____

During your pregnancy did/are you experience any emotional stress? Which trimester?
____
____

Identify any areas of pain (circle all that apply)
Neck Mid Back Low Back Ribs Arms/Hands Legs

Structural Notes:
____
____
____

Pregnant weight gain: _________

Identify any diagnosis received during pregnancy (circle all that apply)

Gestational Diabetes	High Blood Pressure	Low Blood Pressure
Pre-Eclampsia	Eclampsia	Protein in Urine
Urinary Infection	Pelvic Inflammatory Disease	Complete Bed Rest
Swollen Ankles	Anemia	Seizures
Heart Problems	Indigestion	Thyroid Problems
Infections	Placenta Misplaced	Abnormal Bleeding
Medications	Yeast Infections	Other Illness (please explain)
Any Hospitalization		

Physiological notes:

____

____

____

How was/is diagnosis managed?

____

____

Did you choose to perform In-Utero Testing? (Please list tests)

____

____

Did you have an ultrasound during your pregnancy? ________ How many? __________
Exposure time for each ______________________________________

Did you have any x-rays during your pregnancy? _____ Reason: ________________

Are you or have you experienced any of the following: (please circle all that apply)

Frequent Urination	Any Blood in Stool/Urine
Frequent Bowel Movement	Any Increase/Decrease in Precious Symptomatology
Constipation	Fatigue
Diarrhea	Energy Boosts
Hard/Loose Stool	Gestational Depression
Irritation	Mood Swings
Fears	Cravings
Avoidances	Fear of childbirth
Post natal Depression	

During your pregnancy did you use any of the following?
Tobacco Products ______________________________
Alcohol ______________________________
Non-Prescribed Drugs ______________________________
Prescribed Drugs ______________________________

Did you take prenatal vitamins? ______
Where did you get your prenatal Vitamins?______________________________________
Did/are you take any additional vitamins? ______________________________________

Did/are you experience any cravings? (List cravings) ______________________________
____

Did/are you experience any avoidances? (List avoidances) ___________________________
____

Were/are you exposed to any unusual fumes or other chemicals during your pregnancy?
____
____

Did/are you experience morning sickness? ________ How long?____________________

Do you have any silver amalgams (fillings)? __________

Where did you live when you conceived this child? ______________________________

Are you vaccinated? _______ When was your last vaccine? Identify__________________

____

Did/are you experience (ing) any personal emotional stress during your pregnancy?
____
Identify subject, detail of stress ____
____

Were you supported through your pregnancy (family, spouse, friends) _______________
____

Did/are you enjoy (ing) being pregnant? ____

Did (are you planning) you attend any Birth Classes? ________ Which one(s)?
____
____