healthspace

PREGNANCY HEALTH HISTORY INFORMATION

Congratulations on your pregnancy! We are here to support you and your partner as much as you need through this exciting time. Please fill in the following information as thoroughly as you can so we can ensure you get the best care possible!

FULL NAME Date:

What is your due date?

About your pregnancy:

Is this your first pregnancy? ○ Yes ○ No

If this is not your first, how many times have you been pregnant? ……………………………………………………………………………

Have you had any complications with previous pregnancies? ○ Yes ○ No (If yes, please explain)

………

If you have had a miscarriage(s), how far along in your pregnancy did it/they occur?

………

Was this pregnancy planned? ○ Yes ○ No

Who is your primary care giver for delivery? ○ Obstetrician ○ GP ○ Midwife ○ Other ……………………………………………..

Name and Contact details: ……

What is your planned location for delivery? ○ Hospital ○ Home ○ Birthing Centre ○ Other ……………………………………….

If at a hospital, which one are you booked into? …………………………………………………………………………………………

Have you a birth plan yet? ○ Yes ○ No

Do you have a Doula? ○ Yes ○ No If yes, please provide name and contact details: …………………………………………...

Any special arrangements for the birth? (planned C-Section, water delivery, birth chair, squat, other)

………

Have you had any testing? (Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other) Please include dates, reasons and results: ………

………

Are you planning on breastfeeding post delivery? ○ Yes ○ No

What was your blood pressure prior to pregnancy within normal range, low or high? ………………………………………………….

What is your present blood pressure and when was it last checked? ……………………………………………………………………

Have you changed your diet/menu since learning of your pregnancy? ○ Yes ○ No

Have you smoked prior to, or along with, this pregnancy? ○ Yes ○ No ○ Quit

Have you had alcohol during this pregnancy? ○ Yes ○ No

Have you had any specific cravings during this pregnancy? ○ Yes ○ No ………………………………………………

Pregnancy Specific Symptoms: please tick if you have/had any of the following:

○ Swelling in the arms or legs	○ Low back pain	○ Upper back pain	○ Neck pain
○ Rib or chest pain	○ Foot pain	○ Digestive Complaints	○ Headaches
○ Heartburn	○ Constipation	○ Nausea/Vomiting	○ Arm or hand numbness/tingling
○ Dizziness/lightheadedness	○ Pain radiating down the leg/s	○ Heart Palpitations	○ Lethargy

Please continue on if this is your first visit with us so we can gather important health and medical history information. Thanks again for taking the time to help us understand you so we can offer the very best care.