YOUR PREGANCY AND HEALTH HISTORY Part 1

Name: **Name of Partner:**
Occupation: **Occupation Partner:**
Your Birth Date: **Your Age:**

The first day of your last period was: Are your periods regular? Y/N **Baby's Due Date:**

PLEASE LIST ALL PREVIOUS PREGNANCIES (including miscarriages)**:**

Year	Place	Normal birth, CS, other?	Complications?	Boy or Girl	Birth Weight

Do you have any ALLERGIES? NO___ YES____*If YES to what?:*_____ *What kind of reaction?:*_____

In this pregnancy so far have you had: *if YES*

_IVF or assisted conception?
_Bleeding?
_Nausea?
_Infections Fever?
_Anything else?

In your immediate family has anyone had:
if YES and write in WHO

_Heart Disease
_High Blood Pressure
_Diabetes
_Depression
_Other mental illness
_Alcohol/Drug problems
_Blood Clotting Disorder
_Inherited Disease
What is the ethnic background of your parents?

Have you ever had: *if YES and **write details***

_Operation(s)
_Problem with anesthesia
_Procedure to uterus or cervix
_Breathing/Lung problems
_Genital Herpes
_Sexually transmitted infection
_Blood clots or bleeding too much
_High Blood Pressure
_Hepatitis
_Stomach or Bowell problems
_Bladder or Kidney problems
_Diabetes
_Thyroid Disease
_Nerve problems
_Severe headaches
_Mental illness: anxiety, depression, other
Anything else important about your health:

Lifestyle

In your own estimation rate your diet: ***circle*** *for GOOD ----* ***underline*** *for "COULD BE BETTER"----* *for NONE*

Veggies Fruit Meat Fish Veg proteins(tofu, beans) Dairy Healthy snacks Junk food Sweets

Do you take folic acid? __Yes __No If yes when did you start?
What do you do for exercise?:
Do you get enough rest?
Do you take a multivitamin?_____ Other supplements or over-the-counter drugs?_____
Do you use any drugs: now or in the past?
Do you/did you smoke cigarettes? Never_____ In the past_____ Quit when?_____
Are you exposed to second hand smoke?
Do you have any stress with money or housing?
Do you sometimes have trouble paying for food at the end of the month after other expenses?
Is there any violence in your life (verbal, physical, to you or to others?)
Who will help you during labour and birth?: later with the baby?:

YOUR PREGANCY AND HEALTH HISTORY *Part 2*

Alcohol Use– Answer for THIS PAST MONTH:	
In a typical week this past month how many days do you drink alcohol?	
On those days how many drinks are usual?	
How many drinks does it take to make you feel high?	
Have people annoyed you by criticizing your drinking?	
Have you felt you should cut down your drinking?	
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	
Score:	

Medications *List any medications you are taking and dose if you know it:*

Preventive Health		
Have you had a pap smear in the past 2 years?		
Have you had a flu vaccine this year?		When:
Have you had Hepatitis vaccines?	Which one: A__ B__ both A and B__	When:
Have you had a Measles/Mumps/Rubella vaccine?		When:

What are your concerns or questions for today's visit?

Notes: