

Supplemental Pregnant Patient History

Name: _____ Date: _____

Due date: _____ How many weeks? _____

Obstetrician/Midwife name: _____

Last visit with the above mentioned and purpose of visit: _____

Labour Support? _____

Pregnancy to this point (including nausea, fatigue, any problems or concerns, blood pressure, general health feeling, etc.)

1st Trimester:

2nd Trimester:

3rd Trimester: (baby position?)

Ultrasounds (how many, when, purpose, etc.)

At any time has the baby been breech, oblique, transverse, etc? _____

Still working? Type of job? _____

Previous pregnancy history: (# of births, miscarriages, vaginal or c-section, problems, etc.)

