Client's Name Partner's Name						MIE	DWIF	ERY I	NTA	KE FC	DRM					
CareCard# / PHN# Home Phone Cell Phone Date of Birth m/d/y Age	Client's Name						Partner's Name									
Date of Birth m/d/y	Street Addres	ss (incl. C	City & I	Postal Co	de)			ļ.								
Date of Birth m/d/y																
Email Address for appointment reminders: Directions to home:	CareCard# / F		Cell Phone			Work Phone			Partner Cell Phone Pa		Partne	artner Work Phone				
Directions to home: Intended Place of Birth	Date of Birth m/d/y Age					Occup	ation		Partne	er Date o	f Birth	Partner Age		Partn	er Occ	upation
Intended Place of Birth	Email Addres	s for app	ointm	ent remi	nders:	<u> </u>		<u> </u>								
Method of contraception date (if known)? Pregnancy test (date/result) Morning sickness No Yes No Ye	Directions to	o home:														
LMP EDD Allergies Allerg																
LMP EDD Allergies						I			1							
Date Place of Weeks at Hours in Delivery Comments Sex Weight Present health	Intended Pla	ace of B	irth			Physi	cian		Ph	one						
Date Place of Birth Weeks at delivery Hours in labour Delivery type Comments Sex Weight Present health Method of contraception Conception date (if known)? Date contraception discontinued Last normal period When first felt movement (16-20 weeks)? Have you experienced any of the following during this pregnancy? Fainting No Yes No Yes Fainting Blurred Vision Diarrhea No Yes Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins Infection	LMP			EDD			Aller	gies								
Date Place of Birth Weeks at delivery Hours in labour Delivery type Comments Sex Weight health Present health Image: All of the Sirth Birth B	Obstatuisal	l liete m	. /:													
Birth delivery labour type health health labour type health labour type health labour labour type health labour la			_					Deliv	ery	Comn	nents	Sex	Weig	ght	Pr	esent
Conception date (if known)? Pregnancy test (date/result) When first felt movement (16-20 weeks)? Have you experienced any of the following during this pregnancy? No Yes No Yes No Yes Diarrhea Fainting Blurred Vision Diarrhea Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins		Bir	th	deli	very	lab	our	1							health	
Conception date (if known)? Pregnancy test (date/result) When first felt movement (16-20 weeks)? Have you experienced any of the following during this pregnancy? No Yes No Yes No Yes Painting Blurred Vision Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins																
Conception date (if known)? Pregnancy test (date/result) When first felt movement (16-20 weeks)? Have you experienced any of the following during this pregnancy? No Yes No Yes No Yes Painting Blurred Vision Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins																
Conception date (if known)? Pregnancy test (date/result) When first felt movement (16-20 weeks)? Have you experienced any of the following during this pregnancy? No Yes No Yes No Yes Painting Blurred Vision Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins																
Conception date (if known)? Pregnancy test (date/result) When first felt movement (16-20 weeks)? Have you experienced any of the following during this pregnancy? No Yes No Yes No Yes No Yes Painting Blurred Vision Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins																
Conception date (if known)? Pregnancy test (date/result) When first felt movement (16-20 weeks)? Have you experienced any of the following during this pregnancy? No Yes No Yes No Yes No Yes Painting Blurred Vision Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins																
Have you experienced any of the following during this pregnancy? No Yes No Yes No Yes Fainting Blurred Vision Diarrhea Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins	Method of o	ontrace	ption	<u> </u>		Date	contra	ception (discor	itinued		Last normal	period			
Have you experienced any of the following during this pregnancy? No Yes No Yes No Yes	Conception	date (if	know	n)?		Pregnancy test (date/result) When first felt move					ment	(16-2	0			
NoYesNoYesNoYesFaintingBlurred VisionDiarrheaAnemiaRubellaConstipationFatigueSpottingHigh blood pressureMorning sicknessInfectionVaricose veins						weeks)?										
NoYesNoYesNoYesFaintingBlurred VisionDiarrheaAnemiaRubellaConstipationFatigueSpottingHigh blood pressureMorning sicknessInfectionVaricose veins	Have you o	vnorion	cod :	nny of t	ha fall	owina	durin	a thic n	roana	ncv2						
Anemia Rubella Constipation Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins	nave you ex	kperieri				Owing	uurin	g tilis þi	egna		Yes			1	No	Yes
Fatigue Spotting High blood pressure Morning sickness Infection Varicose veins	Fainting					Blur	red Vis	sion				Diarrhea				
Morning sickness Infection Varicose veins	Anemia					Rub	ella					Constipation				
	Fatigue					Spo	tting					High blood pressure		e		
Comments	Morning sic	kness				Infe	ction					Varicose v	eins			
	Comments				1	1				1	1					1

Have you experienced any of the following during this pregnancy?

	No	Yes	Amount		No	Yes	Amount		No	Yes	Amount
Coffee				OTC drugs				Alcohol			
Cigarettes				Prescription							
				drugs							

Diet

Vegetarian	Supplements/Medications (List)
Other Special Diet	
Folic Acid Start Date	

Lifestyle Information

ittern
st, etc.)

Client's Mother's Obstetrical History

Chichie 5 Miother 5 t	botcerical instally				
Pregnancies	Births	Miscarriages		Stillbirths	Vaginal births
C-Sections	Forceps	Breech		Twins	Length of labour
Breast-fed?			Client	's birth	

During previous pregnancies did you have any of the following:

	No	Yes		No	Yes		No	Yes
Anemia			Spotting/Bleeding			High Blood pressure		
Constipation			Hemorrhage			Morning Sickness		
Edema			Bladder / Kidney problems			Premature Rupture of Membranes		
Leg cramps			Dizziness / fainting			Wt gain > 35 lbs or <20 lbs		
Pre_eclampsia			Hospitalizations			Postpartum depression		
Varicose veins			Prematurity			Induced labour		
Episiotomy			Tearing			Difficulty with placenta		
Anesthesia			Forceps			Depression after birth		
Comments					Ļ			

Medical History - Past Illnesses No Yes No Yes No Yes **Epilepsy Blood Transfusion** Anemia **Heart Disease** Chicken Pox Anorexia Arthritis Hypoglycemia Thyroid problems Pelvic fractures/breaks Digestive problems Asthma **Blood Disorders** Infections Urinary tract infections Depression/Psychiatric Cancer Varicose veins Illness

Sexual Abuse

Surgery/hospitalization

Reaction to anaesthetic

Comments

Accidents/Injuries

Diabetes

Family History

	No	Yes		No	Yes		No	Yes
Alcoholism/drug abuse			Blood disorders(clotting)			Multiple births		
Cancer(breast or cervix)			Diabetes(age discovered)			Inherited/Ethnic diseases		
Heart Disease			Severe allergies			High blood pressure		
Depression or Psychiatric illness								
Comments	I	<u>I</u>	ı	<u>I</u>	Į.		Į.	

Please add any comments, thoughts, fears or areas you would like discussed: