doctor FOR moms | perinatal & pediatric natural health center

Supplemental Pregnant Patient History

Name: ________________________ Date: ________________________

Due date: ________________________ How many weeks? ________________________

Obstetrician/Midwife name: ____

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

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Labour Support? ____

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

1st Trimester:

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2nd Trimester:

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3rd Trimester: (baby position?)

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

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

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Still working? Type of job? ____

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

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