Client Name ___________________________ DOB ______________

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Current Pregnancy Information

In what week of pregnancy are you? _____________ What is your due date? ______________________

Are you regularly seeing a physician, midwife, or nurse-midwife? ________ Date of Last Visit _____________

Pregnancy Complications/Problems - circle all that apply:

Bleeding   Rapid weight gain   Protein in urine   Cramping   Vomiting
Vision disturbances   Abnormal fetal growth/heartbeat/movements   Varicose veins
Amniotic fluid leakage   Severe nausea   High blood sugar   Headaches
Water retention   High blood pressure   Other: __________________________________

High-Risk Pregnancy Factors - circle all that apply:

Diabetes   Hypertension   Multiples (twins, triplets, etc.)   Under 20/Over 35 years old
Asthma   Rh/genetic problems   Previous complicated pregnancy
Fetal genetic disorders   Haz-mat exposure

Is there other relevant information about this pregnancy or about you that I should know?

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I have provided all my known pregnancy information and will inform my practitioner of any changes in my health.

Signature: ____   Date: ______________________