History of Pregnancy

Date: _____
Name of child: _____ Sex: M F Date of Birth: ___/___/___
Mother's name: _____ How many other children do you have? ____
How long did it take you to conceive (with this pregnancy)? _____months/years
What was the term of your pregnancy (at delivery)? _____weeks (40 weeks is considered full term)
What was your estimated due date? _____

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	Yes	No	Describe
Falls?	☐	☐	_____
Motor Vehicle Accidents?	☐	☐	_____
Near-miss MVA?	☐	☐	_____
High Blood Pressure?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning Sickness?	☐	☐	_____
Indigestion/Heart burn?	☐	☐	_____
Stress?	☐	☐	_____
Seizures?	☐	☐	_____
Swollen Ankles?	☐	☐	_____
Thyroid Problems?	☐	☐	_____
Heart Problems?	☐	☐	_____
Headaches?	☐	☐	_____
Back Pain?	☐	☐	_____
Abnormal Bleeding?	☐	☐	_____
Were You Hospitalized?	☐	☐	_____
Ultrasounds? If yes, how many?	☐	☐	_____
Any Other Illnesses?	☐	☐	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

	Yes	No	Describe
Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescribed drugs?	☐	☐	_____
Prescription medications?	☐	☐	Medication: _____ Reason: _____
Over-the-counter medications?	☐	☐	Medication: _____ Reason: _____

Were you under chiropractic care during your pregnancy? **Y N**
Whom? _____
Did you have massage therapy during your pregnancy? **Y N**
Whom? _____