PREGNANCY HEALTH QUESTIONNAIRE

Today's Date__________

Mother's name: _______________________ Father's name___________________________

1: Current Pregnancy:

Due Date/Week: ______________________________ I am in my: _________ week of pregnancy.
Pre-pregnancy weight: __________________ Current Weight ______________ Height ______________
Childbirth caregiver(s): □ OB/GYN □ Doula □ Midwife
Last visit to caregiver______________ Caregiver name & phone # _______________________________
I plan on giving birth at: Hospital _____________ Home _______________ Birth Center _____________
Name of Hospital or Birth Center
____ _____________________

Supplements currently taking? ________________________ ________________________________
Any traumas during this pregnancy? (Including falls or motor vehicle accidents) If yes, please describe:
____

Any hospitalizations during this pregnancy? If yes, please describe:_______________________________
____

Any medications during this pregnancy, including over the counter medication? If yes, Please describe:
____

Any fertility treatment? If yes, please describe:____
____

Are you experiencing any pain? If yes, please describe:____
____

Please check if you have/had the following this pregnancy:

□ Diabetes □ Anemia □ Morning Sickness □ Indigestion □ Seizures □ Thyroid Problems

□ Swollen Ankles □ Heart Problems □ Abnormal Bleeding □Tobacco use □ Alcohol use

Any other information about your pregnancy? ____
____

(Continue to next page)

2: Previous Pregnancies/Birth History:
(Please describe all previous pregnancies. If this is your first pregnancy, skip this page)

# of previous pregnancies _______ # of previous births _______
Names and ages of children ____
Birth Weight_________________________ __Birth Length_______________________________

Baby delivered at _________weeks gestation

Type of birth: □ Vaginal □ Forceps □ Vacuum Extraction □ Planned Cesarean □ Emergency Cesarean

Baby head presentation: □ Normal □Sunny side up (Face) □ Breech

Location: □ Home □ Hospital □ Birthing Center

Intervention (check all that apply): □ Pitocin □ Cervidil □ Epidural □Pain meds □ Other_________

Medications taken during pregnancy:____

Describe any problems during labor or delivery:
____

Congenital Defects/Abnormalities?
____

Check all that were present: □ Meconium □Jaundice (yellow) □ Cyanosis (blue) □ Fetal distress

<u>Immediately following birth:</u>

APGAR Scores: at 1 minute ___/10 At 5 minutes ___/10

Baby's cry: □ Strong cry immediately □ Weak cry immediately □ Did not cry for ___minutes

Baby's color: □ Pink all over □ Blue face □ Blue hands/feet

Baby's activity: □ Arms & legs actively moving □ Arms moved only □ Legs moved only □ Floppy baby

Intensive care: □ was not required □ was required ___Days in neonatal intensive care unit

Medication given at birth __________________ Vaccines administered _________________

Did you suffer from baby blues or post-partum depression? □ Yes □ No

If yes, how is/was it managed? _______________________________________

Did you have chiropractic care during your previous pregnancies? □Yes □No