Pregnancy History

Name: _____ Date: _____

Estimated due date:_____

Delivering Practitioner: Midwives OB/Gyn Name:_____

Choice of birth place: Home / Hospital Is this your first pregnancy? Yes No

Did you have fertility treatments? Yes No If yes, please explain: _____

_____

Have you experienced any traumas during this pregnancy? (accidents, falls) _____

_____

Have you had any evaluation procedures (Ultrasound, amniocentisis, chiorionic villus sampling)
Please list frequency & reasons:_____

Is this pregnancy being treated as high-risk? Yes No If so, why? _____

Have there been any stressful events in your life during this pregnancy? _____
_____

Are there any symptoms you are experiencing related to the pregnancy? _____

_____

Previous Birth History

How many other births have you had? ____ Were fertility methods used? Yes No

At what week of pregnancy were your previous babies born? _____

Please circle all that pertain to your previous births*: vaginal delivery c-section epidural induction forceps vacuum breech baby presentation back labour*

_____

Previous birthing positions*: Lithotomy (on back with feet up) Squatting On all fours Side-lying Birth stool Birthing water tub Other:* _____

Infant History

Please circle if your babies experienced any of the following:

Premature birth Neonatal ICU Low APGAR scores Low birth weight Failure to thrive
Colic Breathing difficulties Allergies Breastfeeding difficulties Developmental delays
Other:_____