Supplemental Pregnant Patient History

Name: ________________________________ Date: ________________________

Due date: _________________ How many weeks? ___________________________

Obstetrician/Midwife name: ____

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

Labor Support? ____

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

1st Trimester:

2nd Trimester:

3rd Trimester: (baby position?)

Ultrasounds (how many, when, purpose, etc.) ____
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At any time has the baby been breech, oblique, transverse, etc? ____

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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