PREGNANCY – NEW PATIENT QUESTIONNAIRE

Patient Name:________________________________DOB:_______________Date:______________
First day of your last menstrual period:____________
How many weeks pregnant are you? _______ Approx. Due Date:________________

1st pregnancy? Y / N If no, how many other children do you have? __________________________
If no, how many other pregnancies have you had?______________________

Purpose for seeing us today:____

Other doctors / health professionals seen for this condition? Y / N

If yes, please tell us about who you saw and what they did: _______________________________________

Prenatal History
Name of OB-GYN / Midwife / Clinic:____

Complications during this pregnancy? Y / N explain:____

Medications during this pregnancy? Y / N explain:____

Ultrasounds / amniocentesis / other testing? Y / N explain:_____________________________________

Where are you planning on having the baby? Home Birth Center Hospital

Are you planning on having labor support / doula?____

Have you taken / planning to take any childbirth education classes? Y / N Where?_________________

Are you planning on using a specific labor support technique? _____________________________________

Previous Births (not applicable ☐)
Home Birth Center______________________ Hospital__________________________

How many weeks were you at delivery?____

Name of OB-GYN / Midwife / Clinic:____

Describe your labor:____
____

Any complications?____

Exercise and Nutrition
Do you exercise? Y / N What type of exercise? ____
What does your diet consist of?____
Have you had any nausea or vomiting?____
Are you taking a prenatal vitamin? Y / N other supplements? _________________________________
Coffee or other caffeine? Y / N amount per day:_______________________________________