History of Pregnancy

Date of Exam: ___/___/____ Parent's Name: _____
Patient's Name (child): _____ Sex: _____ Birthday: ___/___/____
How many other children do you have? _____ Was this child premature? Y N

Please Check Any Of The Following That Occurred While Pregnant With This Child:

	Yes	No	Describe
Falls	☐	☐	_____
Motor Vehicle Accidents	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Anemia	☐	☐	_____
Morning Sickness	☐	☐	_____
Indigestion	☐	☐	_____
Seizures	☐	☐	_____
Swollen Ankles	☐	☐	_____
Thyroid Problems	☐	☐	_____
Heart Problems	☐	☐	_____
Back Pain	☐	☐	_____
Abnormal Bleeding	☐	☐	_____
Were You Hospitalized	☐	☐	_____
Any Other Illnesses	☐	☐	_____

During This Pregnancy, Did You Use Any Of The Following:

	Yes	No	Describe
Tobacco	☐	☐	_____
Alcohol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Anemia	☐	☐	_____

Doctor's Signature: _____