



It's Been A While: Pregnancy

Name _____ Sex: M F DOB ___/___/___ Age _____
Address _____ City _____ State _____ zip _____
Phone Number _____ E-mail _____@_____.com
Spouse's Name _____ Number _____
Names of Child(ren) & Age(s) _____

It has been a while since we have seen you. Please update us on your life so we can best serve you! We want to know what has changed, what has occurred and what has brought you back. No detail is too small.

Your genes are not your destiny; your environment determines what genes are turned on and how they express. Your biography becomes your biology.

PLEASE NOTE ANY CHANGES/ EVENTS SINCE YOUR LAST VISIT:

Surgery (& year performed) : _____

Accidents/Falls: _____

Relationships (family, friends, significant other): _____

Work: _____

Exercise: _____

Are you: Consciously Pre-Conceiving Conceiving Pregnant Guess (due) Date: _____
Conscious Conception? Y N Fertility Issues? Y N Fertility Measures Taken? Y N Third trimester presentation: Head Down Transverse Lie Breech

Do you have: OBGYN Midwife Doula Lactation Consultant Postpartum Doula/ Baby Nurse

Have you experienced any of the following during this pregnancy:

- Morning Sickness/Vomiting/Nausea Difficulty Sleeping Constipation Gestational Diabetes
- Indigestion High Blood Pressure Sciatic Pain Low back Pain Pubic bone Pain Heartburn
- Headaches Pre-Eclampsia Bladder/ Kidney Infection Pregnant with Multiples Placental Dysfunction

CHEMICAL STRESS- Anything you inhale, ingest or absorb

When was the last time you were on birth control? _____

Current Medications (Name, Dose & Taken Since) : _____

Previous Medications (Name & When/ how long taken) _____

Rounds of Antibiotics _____

Do You: Drink Alcohol _____x/ week Drink Soda ____x/week Use Drugs Eat Packaged Food
 Eat Organic _____% Eat Non GMO Smoke _____packs/ week Use Air Purifier Use Water Filter
 Use Shower Filter Sugar in Coffee Sugar in Coffee Drink _____oz of water per day

Current Diet: Vegetarian Pescatarian Vegan Keto Paleo Dairy-free Soy-Free Gluten-Free
Other Chicken Fish ____x/ week Red Meat ____x/ week

What do your typical meals look like?

Breakfast: _____

Lunch: _____

Dinner: _____

EMOTIONAL/MENTAL STRESS: These stresses have a major affect on how our body processes and feels.

Occupation _____ Do you enjoy what you do: Y N

Have you ever experienced the following?

- Mental Abuse Physical Abuse Rapid life change Career change Divorce/ Separation Loss of Child
- Sexual Abuse Major move Being far from family/friends Care provider for child/children
- Financial Concern Care Provider for parent Loss of a loved one

CURRENT HEALTH CONCERNS

What is the reason for this reservation? _____

When did this begin? _____ Have you had this before? _____

Why do you think this is occurring? _____

Is there any other issue/secondary condition that you believe is related to this? _____

Have you gotten any other advice or treatment for this issue? (if yes than from who and what was result)

What activities aggravate your condition? _____

What activities relieve your condition? _____

Is the condition worse during certain times of the day? Y N If yes, when? _____

Does it affect: Mood, patience, attitude Sleep exercise or play day-to-day activities Ability to work
 decision making relationship or intimacy

What are your healthcare goals? _____

CURRENT HEALTH CARE TEAM:

OB/MIDWIFE: _____ Are you Happy with them? Y N

DOULA/ POSTPARTUM DOULA: _____

BIRTH ED CLASS: _____

I would like more information/ Recommendations for: Having a natural birth A Doula A postpartum Doula

Birth Ed Class Other: _____

Patient Signature _____ Date _____