# Prenatal Health History Form

In order to provide you the best possible care, please complete this form and bring it with you to your first appointment.

All information is strictly CONFIDENTIAL.

## Patient Information

First name: ___________________________ Last Name: _______________________________ Date: _______________

Address: _______________________________________________________ City: _______________________________

State: ___________ Zip Code: _____________ Primary Phone (Cell/Home/Work): _______________________________

Secondary Phone (Cell/Home/Work): ______________________________ Email: _______________________________

Date of Birth: ________________________ Height: _______________ Weight: _____________ Children: ____________

Occupation: ____________________________________ Employer: ___________________________________________

Maternity Leave? (if applicable) Yes No How long? ____________________________________

Marital Status: ___________________ Spouse/Partner: ____________________________________________________

Spouse Occupation: ______________________________ Employer: __________________________________________

Emergency Contact: _______________________________________ Phone: ____________________________________

## Patient Health

This pregnancy is: Planned Unexpected

(Circle all that apply) Natural Fertility

Briefly describe your current complaint/injury: ____________________________________________________________

_______________________________________________________Date symptoms appeared: _____________________

Have you ever had the same condition: Yes No If yes, when? __________________________________

Have you been treated for any other conditions in the last year? Yes No

If yes, please describe: _______________________________________________________________________________

Date of last physical exam/prenatal exam: _______________________

| Symptom description | Yes | No |
|---|---|---|
| Do you experience pain every day? | o | o |
| Do your symptoms interfere with daily life? | o | o |
| Does pain wake you up at night? | o | o |
| Are your symptoms worse during certain times of the day? | o | o |
| Do you wear orthotics | o | o |
| Do you take vitamin supplements? | o | o |
| What activities aggravate your symptoms? | | |

What medications are you taking and for what conditions? (Please list dosage and amounts, etc.)

____________________________________________________________________________________________

____________________________________________________________________________________________

What vitamins, minerals or herbs do you currently take? (Please list conditions, dosage, and frequency).

____________________________________________________________________________________________

____________________________________________________________________________________________

| **Have you ever:** | **Yes** | **No** | **Briefly explain:** |
|---|---|---|---|
| Broken bones? | o | o | |
| Been hospitalized, not associated with pregnancy? | o | o | |
| Been hospitalized, associated with pregnancy? | o | o | |
| Been in an auto accident? | o | o | |
| Had sprains/strains? | o | o | |
| Been struck unconscious? | o | o | |
| Had surgery? | o | o | |

| **Habits:** | **None** | **Light** | **Moderate** | **Heavy** |
|---|---|---|---|---|
| Alcohol | o | o | o | o |
| Coffee | o | o | o | o |
| Tobacco | o | o | o | o |
| Drugs, non-prescribed | o | o | o | o |
| Fish | o | o | o | o |
| Exercise | o | o | o | o |
| Sleep | o | o | o | o |
| Appetite | o | o | o | o |
| Soft Drinks | o | o | o | o |
| Water | o | o | o | o |
| Salty Foods | o | o | o | o |
| Sugary Foods | o | o | o | o |
| Artificial Sweeteners | o | o | o | o |

## **Insurance Information (if applicable)**

Name of party responsible for payment: ____________________________________________________________

Do you have health insurance? Yes No Name of company: ______________________________

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsible for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services to me will be immediately due and payable.

**I hereby verify all information provided is correct and true. I understand the insurance agreement, as it pertains to my treatment.**

Patient Signature: ______________________________________________ Date: __________________________