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 ____________________