Pregnancy History

Child's Full Name: _____ Date: _____

Mother's name: _____

What was the term of your pregnancy? _____ weeks

During your pregnancy, did you experience any of the following:

	YES	NO	If yes, describe:
Falls	☐	☐	_____
Motor vehicle accidents	☐	☐	_____
Near miss MVA	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Anemia	☐	☐	_____
Morning sickness	☐	☐	_____
Indigestion	☐	☐	_____
Seizures	☐	☐	_____
Swollen Ankles	☐	☐	_____
Thyroid Problems	☐	☐	_____
Heart Problems	☐	☐	_____
Back Pain	☐	☐	_____
Abnormal Bleeding	☐	☐	_____
Where you hospitalized?	☐	☐	_____
Any other illnesses	☐	☐	_____

During your pregnancy, did you use any of the following:

	YES	NO	If yes, describe:
Tobacco	☐	☐	_____
Alcohol	☐	☐	_____
Non prescribed drugs	☐	☐	_____
Prescription Medication	☐	☐	_____
Over the counter Meds	☐	☐	_____

Reason for Medications: _____
_____
_____

I certify that that the above information is correct to the best of my knowledge. I will not hold my doctor or any Members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Parent's Signature: _____ ____ Date: _____

Reviewed by Doctor: _____ Date: _____