



Health History - Page 2

Name _____ Date _____ Code _____

Family History: Check to note a family history.

Condition:	Yourself	Father of Baby
	Parents G-Parents Siblings	Parent s G-Parents Siblings

Heart Conditions						
High Blood Pressure						
Diabetes: Type 1						
Type 2						
Cancer, Tumors						
Liver & Kidney Diseases						
Thyroid, Endocrine Diseases						
Psychological, Severe Emotional Disorders						
Alcohol, Drug Abuse						
Epilepsy, Seizure Disorders						
Genetic Problems						
Other:						
Multiple Births						

Your Mother's Obstetric History:

of Pregnancies _____ # of live births _____ Your birth weight _____

How do you describe your labors? _____

Notable complications or issues: _____

Your Previous Pregnancies:

Total # _____ Living Children _____ Miscarried _____ Terminations _____ Adopted _____ Pre-Term _____

Stillborn _____ Multiple Births _____ Ectopic _____ Caesareans _____

Your Previous Births:

Name: Sex Place #Wk. Weight Hr of L Hr of P Tear/Epis Meds? Notes:

RH- Did you receive Rhogam after each pregnancy? _____ How many times have you bled a lot? _____

If you have had a miscarriage or termination, did you have Infection Incomplete Emotional Trauma

How many of your babies have you breastfeed? _____ For how long? _____

Problems? _____