Maternal Health History Intake Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Emergency Contact

Contact Name

Phone Number

Relationship to You

Pregnancy History

Number of Pregnancies (Gravida)

Number of Births (Para)

Number of Miscarriages/Abortions

Number of Living Children

Current Pregnancy - Weeks Gestation

Estimated Due Date

Past Pregnancy Details

Medical History

Do you have any of the following conditions?

Diabetes
High Blood Pressure
Thyroid Disorders
Heart Disease
Epilepsy
Other

If other or additional, please specify

Allergies

List all known allergies (medication, food, etc.)

Current Medications/Vitamins

List all current medications and dosages (including prenatal vitamins & supplements)

Surgical History

List any major surgeries and year

Family History

Any family history of genetic disorders, diabetes, hypertension, or other significant conditions?

Social History

Do you smoke?

Do you consume alcohol?

Any recreational drug use?

Other Notes or Concerns