Posture Plus

Maternity Health History Form

Name_____ Date_____

How many weeks pregnant are you?_____ What is your due date?_____

This is my_____(number of pregnancy 1st, 2nd, etc) pregnancy

Was the pregnancy planned? (circle): yes no

Prenatal care provider/doctor_____

May I have permission to contact your care provider/doctor? Yes No

Date of last visit to primary care provider_____

Position of baby (from week 28) if known_____

History of previous labours_____

_____

Have you had any complications with this pregnancy? Such as bleeding, cramping, amniotic fluid leakage, water retention, high blood pressure, rapid weight gain, protein in urine, high blood sugar, vision disturbances, severe nausea, vomiting, headaches, or abnormal fetal growth, heartbeat or movement? Please circle all that apply. Other_____

_____

_____

Is your pregnancy considered to be high risk?_____

Are you experiencing diabetes, hypertension, multiple pregnancy, asthma, or genetic problems? Please circle all that apply. Other_____

Please list any medications you are taking and for what condition_____

_____

Please read and sign:

I have completely read and answered all the questions above to the best of my knowledge and will notify my Massage Therapist of any health changes during my pregnancy. I understand that all information gathered remains confidential.

Signature: _____ Date: _____