Dr. Corey
ND RMT RAc

Prenatal History and Intake form

Name: _____ Age: _____ DOB: _____ Cultural Birth Practices:_____
_____

Expected Due Date: _____ Blood Group: ☐A ☐B ☐AB ☐O Rh factor: negative☐ positive☐
Address: _____ City: _____ Prov: _____
Postal code: _____ Phone number: _____ Cell: _____
Occupation: _____ Partner: _____ Partners' age: _____
Partners' occupation: _____
Date of First visit: _____
Family physician: _____ phone number: _____
Obstetrician: _____ phone number: _____
Midwife: _____ phone number: _____
Birth assistant/Doula: _____ phone number: _____

Obstetrical history:

Gravida: _____ Para: _____ Abortions: _____ Stillbirths: _____ Miscarriages: _____
C-sections: _____ Breech births: _____ Twins: _____ Bleeding: _____
Description of past deliveries and pregnancies:

Date: _____ Date: _____ Date: _____ Date: _____
Wt of baby 1: _____ baby 2: _____ baby 3: _____ baby 4: _____
Sex of baby 1: _____ baby 2: _____ baby 3: _____ baby 4: _____
Length of Labour baby 1: _____ baby 2: _____ baby 3: _____ baby 4: _____
Complications/interventions baby 1: _____ baby 2: _____

baby 3: _____ baby 4: _____
Feelings about past experiences/pregnancies: _____
_____
_____
_____
_____

Height: _____ Pre-pregnancy wt: _____ Present wt: _____
BP sitting: _____ BP standing: _____
How was pregnancy confirmed (e.g. home test, doctor's office): _____
Planned pregnancy?☐YES/NO☐ Wanted pregnancy?☐YES/NO☐
Any bleeding since conception?☐YES/NO☐ If yes, how much/often? _____
Assisted Conception?☐YES/NO☐
Contraception: Type: _____ Duration: _____

Used and last used: _____

Diet:

Vegetarian? ☐YES/NO☐ How long? _____
Favourite foods: _____
Food cravings: _____
Cultural/religious restrictions: _____
How much water consumed and from what source: _____
Foods most often consumed: _____
Amount of tea/coffee/soft drinks each day: _____
Hypoglycaemic tendencies: _____
Bowel movements per day – quality, colour: _____
Medical risk factors that could affect nutritional status especially diabetes, anaemia, colitis, eating disorders, addictions, metabolic disorders and any previous surgery on the GI tract: _____
_____
_____
_____

Social and Economic history: medical coverage, food assistance programs, assistance form partner and/or family: _____
_____
_____
_____

Gynecological History:

Date of last menstrual period, are you certain of the date: _____
Was the LMP normal: _____
Age of menarche: _____
Length of cycle: _____
Character of the flow – colour, clots: _____
Length of bleed: _____ Regular cycles☐YES/NO☐ Dysmenorrhea☐YES/NO☐
PMS☐YES/NO☐ Sx, type, intensity, duration: _____
Type of menstrual device used (tampon/pad) Intermenstrual bleeding: _____
Post-coital bleeding: _____ Vaginal discharge: _____
Pelvic pain (time, nature, relationship to periods, intercourse, urination/defecation, movement, eating):
_____
_____
_____
Urinary tract problems: _____
Venereal disease: _____
Vaginal yeast infections: _____
Cysts, tumours, endometriosis: _____
D&C – dates and reasons: _____

Dr. Corey
ND RMT RAc

Last Pap test? _____ Any abnormal PAP results in past? _____

Plans for Current Pregnancy:

Type of birth attendant chosen (GP, OBGYN or midwife: _____ Birth Assistant/Doula?
Home/Hospital birth? Arrangements for the other children: _____
Breastfeeding? _____ Prenatal Education: _____
Continuing at work/home

Lifestyle:

Exercise program: _____
Stress level in life – where is stress coming from: _____
_____
How much alcohol/cigarettes/recreational drugs per day/week: _____
_____
Exposure to drugs, abusive habits, chemicals, toxins, radiation, extreme temperature, loud noises, infective agents: _____
_____
Pets:
_____

Medical History:

Complete ROS: _____
Medications presently taking: _____
_____
Vitamins/remedies presently taking: _____
_____
History of transfusions: _____
Any accidents: _____
Any broken bones: _____
Any surgeries – procedure, date, doctor, hospital, diagnosis, prognosis, complications: _____
_____
_____
_____
_____
Personal trauma (rape, abuse): _____
Emotional/psychological problems or past diagnosis: _____
_____
Bleeding disorders: _____

Family History:

History of high blood pressure, clots, bleeding, tuberculosis, kidney problems, congenital abnormalities, stroke, cardiovascular disease, diabetes (age discovered), cancer, twins, other.

Dr. Corey
ND RMT RAc

Maternal Mother's Obstetrical History:

How many children did your mother have? _____ How many born in hospital _____
How many born at home? _____ Ceasarean: _____ Breach: _____
Complications of pregnancy or birth: _____
_____
Length of labour: _____ Length of pregnancies: _____
Attitude toward birth: _____
Were children breastfed? _____ Any breastfeeding difficulties? _____
Did she ever take diethylstilbestrol (DES) while pregnant with you? _____

Father's History:

Exposure to drugs, abusive habits, chemicals, toxins, radiation, extreme temperature, loud noises, infective agents: _____
_____
Congenital abnormalities:
_____
Family History of twins, heart disease, diabetes, epilepsy: _____
_____
Feelings toward the pregnancy: _____