Prenatal Health History Assessment Form

Please complete this form as accurately as possible to help us provide the best care during your pregnancy.

1. Personal Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Emergency Contact Name:

Emergency Contact Relationship:

Emergency Contact Phone:

2. Menstrual and Obstetric History

First Day of Last Menstrual Period (LMP):

Are your menstrual cycles regular? (Yes / No / Details):

Total Number of Pregnancies (including this one):

Number of Full-Term Births:

Number of Pre-Term Births:

Number of Miscarriages or Abortions:

Number of Living Children:

Details of previous deliveries (Year, delivery type, complications):

3. Medical History

Do you have or have you ever had any of the following? (Please type Yes, No, or details)

High Blood Pressure:

Diabetes or Gestational Diabetes:

Heart Disease:

Asthma or Respiratory Issues:

Thyroid Disorders:

Depression, Anxiety, or Mental Health Conditions:

Known Allergies (Medications, Food, Environmental):

Current Medications and Supplements (with dosages):

4. Surgical and Gynecological History

Previous Surgeries (list procedure and year):

History of Gynecological Surgeries (e.g., C-section, Myomectomy, LEEP):

5. Family and Social History

Family history of genetic disorders, birth defects, or chronic conditions:

Do you smoke or use tobacco/nicotine products? (Yes / No / Past):

Do you consume alcohol? (Yes / No):

Do you use any recreational substances? (Yes / No / Details):

Occupation and physical demands of work:

6. Form Completion Details

Form Completed By:

Date Completed (MM/DD/YYYY):