PREGNANCY SURVEY

Name: _____ Date: _____

Date of Birth: _____ Phone: _____ E-Mail: _____

Social Security: _____ Address: _____

_____

Which pregnancy is this for you? _____ List Children & Ages: _____

What is your "Guess" date? _____ How many Weeks? _____

Who is your Midwife? _____ Address/Phone _____

_____

Who is your OB/GYN? _____ Address/Phone _____

_____

Are you seeking Doula services as well? _____ Doula's Name _____

Where are you planning to deliver? O Home O Birthing Center O Hospital

If Birth Canter or Hospital, please list: _____

Are you experiencing any of the following pregnancy related symptoms?

Morning Sickness	Leg Pain
Headaches	Back Pain
Swelling – Legs, Feet, Ankles, Hands, Face	Pubic Pain
Arm/ Wrist Pain	Difficulty sleeping
Round Ligament Pain	Fatigue
Altered Gait	Spotting
Cramping	Heartburn/Dig. Problems

Food Cravings: _____

Do you currently have or have had any of the following difficulties with this or any previous pregnancies?

Malpresentation: Transverse	Breech	Brow/Facial	Occiput Posterior
Induced Labor	C-Section		Epidural
Vacuum Extraction	Episiotomy		Forceps

Please list any Prescription or over-the-counter medications that you are currently taking:

_____

_____

Vitamins/ Herbs/ Minerals

_____

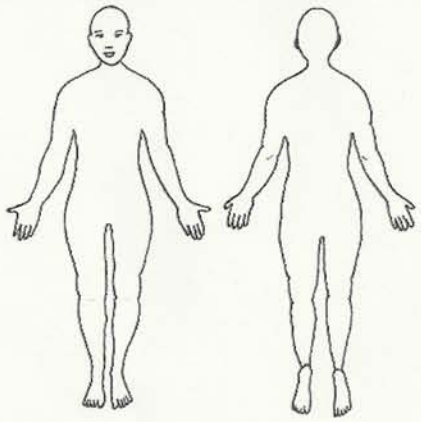
_____

Allergies

_____

_____

Please indicate on the picture where you are currently having pain:



Type of Pain:

Sharp	Pulling
Burning	Cramps
Shooting	Stiffness
Tingling	Swelling
Dull	Pressure
Aching	Heaviness
Throbbing	Weakness

How often do you have this pain? _____ Is it constant or does it come and go? _____

When did your symptoms first appear? _____

Place a check to indicate if you have had any of the following:

AIDS/HIV		Emphysema		Migraine Headaches		Sexually Transmitted Disease	
Alcoholism		Epilepsy		Miscarriage		Stroke	
Allergy Shots		Fractures		Mononucleosis		Suicide Attempt	
Anemia		Glaucoma		Multiple Sclerosis		Thyroid Problems	
Anorexia		Goiter		Mumps		Tonsillitis	
Appendicitis		Gonorrhea		Osteoporosis		Tuberculosis	
Arthritis		Gout		Pacemaker		Tumors, Growths	
Asthma		Heart Disease		Parkinson's Disease		Typhoid Fever	
Bleeding Disorders		Hepatitis		Pinched Nerve		Ulcers	
Breast Lump		Hernia		Pneumonia		Vaginal Infections	
Bronchitis		Herniated Disk		Polio		Whooping Cough	
Bulimia		Herpes		Prostate Problems		Other:	
Cancer		High Blood Pressure		Prosthesis			
Cataracts		High Cholesterol		Psychiatric Care			
Chemical Dependency		Kidney Disease		Rheumatoid Arthritis			
Chicken Pox		Liver Disease		Rheumatic Fever			
Diabetes		Measles		Scarlet Fever			

Exercise: _____

Work Activity: _____

Injuries & Surgeries:

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____