Inanna Birth & Women's Care
940-483-1569

Name _____ ***DOB*** _____

PREGNANCY REVIEW

First day of last period _____ ☐ **sure** ☐ **approximate** **Normal? Y N**
Last normal period _____ **Planned pregnancy? Y N**

Your feelings about pregnancy _____
Biggest concern or fear _____
Partner's Feelings about pregnancy & birth center choice _____
Biggest concern or fear _____
Reason for choosing birth center _____
Do you plant to breast-feed? ☐ **Yes, experienced** ☐ **Yes, inexperienced** ☐ **Undecided** ☐ **N**

Have you had any of the following problems during this pregnancy?

- ☐ **Nausea**
- ☐ **Vomiting**
- ☐ **Fever**
- ☐ **Headache**
- ☐ **Dizziness**
- ☐ **Indigestion**
- ☐ **Leg Cramps**
- ☐ **Rash**
- ☐ **Backache**
- ☐ **Swelling**
- ☐ **Constipation**
- ☐ **Diarrhea**
- ☐ **Urinary complaints**
- ☐ **Abdominal/pelvic pain**
- ☐ **Vaginal bleeding/spotting**
- ☐ **Vaginal discharge**
- ☐ **Varicose veins**
- ☐ **Hemorrhoids**
- ☐ **Loneliness**
- ☐ **Depression**
- ☐ **Family/relationship problems**
- ☐ **Work problems**
- ☐ **Other** _____

Have you used or been exposed to any of the following during this pregnancy?

- ☐ **Tobacco**
- ☐ **Alcohol**
- ☐ **Caffeine**
- ☐ **Street drugs**
- ☐ **Industrial fumes**
- ☐ **X-Ray**
- ☐ **Vaccinations**
- ☐ **Cats**
- ☐ **Other**

Have you, or the baby's father ever:
Y N Had a baby with birth defects or mental retardation?
Y N Had a family member with inherited or genetic problems?
Y N Had Hepatitis?
Y N Thought you are likely to have a baby with birth defects?
Y N Are you a blood relative of the baby's father?
Y N Are you or the baby's father? (circle) Jewish African American Asian Mediterranean Eskimo Haitian

List all vitamins, herbs, prescription and non-prescription medications you are currently taking:

_____

_____