Patient Medical Sheet - Pregnancy

Patient: First Name: ____________________ Last Name: ____________________

Partner: First Name: ____________________ Last Name: ____________________

Current Pregnancy

First Day of Last Period: Estimated Due Date:

Was Conception: Spontaneous ☐ Ovulation Drugs ☐ IVF ☐

Do you Smoke? No ☐ Yes ☐ ________ per day

Do you use recreational drugs? No ☐ Yes ☐ ________ per day

Do you drink alcohol when you are **not** pregnant? No ☐ Yes ☐ ________ per day/week/month

There is no safe level of alcohol consumption in pregnancy

Last PAP Smear/CST date: __________ Result: __________

How many pregnancies have you had in total? **(including the current pregnancy)** ☐

Miscarriages: ☐ Terminations: ☐

Date of Birth	Pregnancy details (diabetes, bleeding, prematurity)	Birth details (forceps, caesarean section)	Baby's weight

Any previous surgery: ____

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Hypertension: Yes ☐ No ☐ Details ____________________

Diabetes: Yes ☐ No ☐ Details ____________________

Thyroid: Yes ☐ No ☐ Details ____________________

Asthma: Yes ☐ No ☐ Details ____________________

Anxiety/Depression Yes ☐ No ☐ Details ____________________

Epilepsy: Yes ☐ No ☐ Details ____________________

Allergies Yes ☐ No ☐ Details ____________________

Current Medications: Yes ☐ No ☐ Details ____________________

OTHER: ____

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Any relevant Family History: ____

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