

PLEASE DESCRIBE YOUR PREGNANCY:

1. Describe any complications during this pregnancy:

<i>What?</i>	<i>When?</i>	<i>Treatment?</i>
<input type="checkbox"/> illnesses		
<input type="checkbox"/> spotting/bleeding		
<input type="checkbox"/> infections, rashes or fevers		
<input type="checkbox"/> hospitalizations		
<input type="checkbox"/> accidents		
<input type="checkbox"/> high blood pressure		
<input type="checkbox"/> toxemia/pre-eclampsia		
<input type="checkbox"/> diabetes/sugar in urine		
<input type="checkbox"/> too much fluid around the baby		
<input type="checkbox"/> too little fluid around the baby		
<input type="checkbox"/> premature labor		
<input type="checkbox"/> other problems		

2. Describe your exposure to the following during this pregnancy:

<i>What?</i>	<i>How much?</i>	<i>When?</i>
<i>Prescription or over-the-counter medications</i>		
<i>Other drugs (include street drugs; narcotics)</i>		
<i>Alcohol</i>		
<i>Other (e.g. Xrays, chemicals, workplace)</i>		

3. When did you first feel the baby moving? _____

4. Would you describe the baby's movements as: 1) very active, or 2) moderately active, or 3) less active than you expected? _____

5. Describe testing done during the pregnancy, such as:

<i>Test</i>	<i>When and why (if known)</i>	<i>Result (if known)</i>
<input type="checkbox"/> AFP (alphafetoprotein), 1 st trimester, triple or quad screen		
<input type="checkbox"/> Ultrasound		
<input type="checkbox"/> Amniocentesis or CVS		
<input type="checkbox"/> Other		

6. Describe the delivery:

When?

- ___ within 2 weeks of due date
- ___ premature by ___ weeks
- ___ late by ___ weeks
- ___ other _____

Type of delivery?

- ___ normal (head first) vaginal delivery
 - ___ breech delivery
 - ___ forceps delivery
 - ___ C-section (if C-section, please explain why) _____
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7. Were there complications with the delivery? _____. If yes, please describe:

8. Other comments:

Name of person completing this form _____

Current date _____