Pregnancy Intake Questionnaire

Name: ____ Date: ____________________

Which pregnancy is this for you? ______________________ Due Date: __________________

Date of previous deliveries Outcome:

Who is your midwife? __________________________

Who is your OB/Gyn? __________________________

Who is your doula? ____________________________

Where are you planning to deliver? At home_______ Hospital ________ Other: ______________

Are you having any of the following symptoms with this pregnancy?

____ Morning sickness ____ Arm pain ____ Difficulty sleeping

____ Headaches ____ Leg pain/ ache ____ Swelling

____ Heartburn ____ Back pain ____ Varicose veins

____ Indigestion ____ Sciatic pain

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

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Please list any vaccines you have had during your pregnancy

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Please list any vitamins/supplements that you are currently taking

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Stephanie A. Hoglund, DC
3935 N 75 W
HYDE PARK, UT 84318
435-232-0732