WHOLE|medicine
14127 Capri Drive, Suite 5A
Los Gatos, CA 95032
408.884.1972

Date: _____

Name: _____ Age: _____ Date of Birth: _____
(first) (middle) (last)

Pregnancy

Are you pregnant? ☑ Yes ☐ No

If so, how many weeks? _____

Estimated Due Date _____

OB/Midwife name _____

OB/Midwife Phone _____

Please check or list below any risk factors which apply to your pregnancy:

☐ Anemia	☐ Asthma	☐ Blood disorders
☐ Breech position fetus	☐ Cardiac disorders	☐ Convulsive disorders
☐ Cramping/contractions	☐ Diabetes, type _____	☐ Drug/alcohol use
☐ Group B strep positive	☐ Herpes	☐ Hyperemesis
☐ Hypertension (gestational?)	☐ Liver/gallbladder disorders	☐ Multiple pregnancy
☐ Ovarian cyst	☐ Placenta previa	☐ Renal disorders
☐ Rh negative	☐ Spotting or frank bleeding	☐ Thyroid disorder
☐ Uterine abnormalities	☐ Uterine fibroid	

Other: _____

Are there any known fetal abnormalities? (Please list) _____

_____

What course of treatment has been taken for the above? _____

_____

Were there complications of a previous pregnancy, birth, or postpartum? ☐ Yes ☐ No

If so, please describe details, treatment, and resolution: _____

_____

Are you experiencing any pregnancy-related discomfort? ☐ Yes ☐ No

If so, please check or list below:

☐ Constipation	☐ Emotional changes	☐ Feet/ankle swelling
☐ Headache	☐ Heartburn	☐ Hemorrhoids
☐ Indigestion	☐ Nausea	☐ Sciatica/back pain
☐ Sleep disturbance	☐ UTI	☐ Varicosities

Other: _____