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PREGNANCY EVALUATION MEDICAL HISTORY FORM

DATE: _____

CHART #: _____

NAME OF CLIENT: _____

DATE OF BIRTH: _____

Current Medical History

When was the first day of your last normal menstrual period (date)? _____

This period was: on time _____ early _____ late _____

The amount of bleeding was: normal _____ lighter _____ heavier _____

Are your cycles: regular _____ irregular _____

*Any bleeding or spotting since last period? yes _____ no _____

*Any pain in your lower abdomen since the last period? yes _____ no _____

Check any symptoms that you have noticed recently:

Breast tenderness/swelling _____ Excess fatigue _____ Nausea _____

Swelling in abdomen _____ Increased urination _____

Shoulder pain _____

*Persistent one or two sided lower abdominal pain _____

Have you had intercourse since your last period? yes _____ no _____

Did you use birth control? yes _____ no _____

Check current method(s) of birth control:

Pill _____ Norplant _____ Depo Provera _____

*IUD _____ Condom _____ Diaphragm _____

Natural Family Planning _____ Withdrawal _____

None _____

Were you planning a pregnancy at this time? yes _____ no _____

Have you been pregnant before? yes _____ no _____

If yes, please indicate the dates of:

previous live births _____

previous miscarriages _____

previous tubal pregnancies _____

previous abortions _____

previous stillbirths _____

OVER

