Personal Details

PERSONAL DETAILS

Name: _____ Address: _____

Best Contact Number: _____ Date of Birth & Age: _____

How many pregnancies have you had in total (including losses or terminations)?:

How many living children do you have?: _____

When was your first day of your last period?: dd / mm / yyyy

How long is your monthly cycle (from day one of one period to day one of the next?):

Regular Medication Taken:

Smoker: _____ Alcohol consumption pre pregnancy: _____

Drug use pre pregnancy: _____ Any continuing drug / alcohol use?: _____

Do you feel safe in your own home?: _____ Do your children live with you?: _____

In your previous pregnancies did you have any of the following health complications?

- [ ] diabetes
- [ ] high blood pressure
- [ ] large / small baby
- [ ] blood clots

Please also indicate if any of these are present in either expectant parents immediate family

- [ ] diabetes
- [ ] high blood pressure
- [ ] large / small baby
- [ ] blood clots

Did you baby have any of the following; genetic disorder / hearing problems / heart problems / any other abnormality

Have any of your babies been stillborn?:

Premature birth?: _____

BRIEF SUMMARY OF YOUR PREGNANCIES:

Pregnancy 1

How many weeks pregnant were you when your baby was born?:

What type of birth did you have?

◯ induction ◯ spontaneous vaginal birth ◯ forceps or ventouse ◯ c section

Was your pregnancy a straightforward healthy one?:

Was your baby born healthy and well?:

Did you have any problems after your birth?:

Pregnancy 2

How many weeks pregnant were you when your baby was born?:

What type of birth did you have?

◯ induction ◯ spontaneous vaginal birth ◯ forceps or ventouse ◯ c section

Was your pregnancy a straightforward healthy one?:

Was your baby born healthy and well?:

Did you have any problems after your birth?:

If you need to tell us about more pregnancies, or anything else please do so here:

GENERAL HEALTH QUESTIONNAIRE - HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Allergies (to what and severity)

Asthma or Chest problems / pulmonary embolism

Kidney Problems / Recurring UTI's

Diabetes (pregnancy related or otherwise)

Thyroid Problems

Heart Problems

Any Thalassaemia, sickle cell or clotting problems?

Have you Ever had a blood clot?

Anaemia?

Ever had an STD?

FGM? Or piercings?

Hepatitis

HIV

Ever had a seizure or neurological problem

Mental Health Problems (current or medicated)

Any problems with your digestive system (Crohn's /IBS)

Any previous operations?

Any broken bones?

Migraine

Do you have any autoimmune conditions like Lupus / Fibromyalgia / Arthritis

Do you have any problems with bladder or bowel control (incontinence?)

Have you had any bleeding in this pregnancy

Any vitamin deficiency (vit D, B12 etc)

Do you work with chemicals / gases / exposed to substances?

What would you like to discuss during your appointment?

Are you booked with an NHS hospital – which one:

BENEFITS AND ENTITLEMENTS

Have you received your FW8 (maternity prescription exemption) (after 9+6 weeks):

Do you require a MATB1 form (after 20 weeks):

Sure Start Form (if applicable):

We can only complete FW8 / Mat B1 / Sure start form etc with proof of ID such as passport or driving licence and provided you are at the pregnancy point listed above, AND you have entitlement to NHS Care. This is due to guidance on fraud prevention.