

# Pregnancy Health History

Name: \_\_\_\_\_

1. What discomforts, pain, or other needs are you hoping to have addressed through this massage therapy?
2. In what week of pregnancy are you? \_\_\_\_\_
3. Are you regularly seeing a physician, nurse-midwife, or midwife? Who? Phone?
4. Have you had any complications or problems with this pregnancy? Circle those applicable: bleeding, cramping, amniotic fluid leakage, water retention, high blood pressure, rapid weight gain, protein in urine; vision disturbances, severe nausea, vomiting, or headaches; abnormal fetal growth, heartbeat, or movements, high blood sugar, other:
5. Do you have any medical conditions? Circle those applicable: diabetes; heart, liver, kidney or lung disorders; convulsive disorders, uterine abnormality, connective tissue or collagen diseases, other:
6. Are you currently experiencing any infection or disorder? Circle those applicable: cold, bladder infection, skin irritation, varicose veins, others:
7. Is your pregnancy considered to be high risk? (diabetes, hypertension, multiple pregnancy, previous complicated pregnancy, asthma, RH or genetic problems, under 20 or over 35 years old, fetal genetic disorders, or exposure to hazardous materials)
8. Is there other relevant information about this pregnancy or about you that I should know?