PREGNANCY CONSULTATION FORM

CLIENT'S NAME:		GP MIDWIFE:	
ADDRESS:		PRACTICE	
TEL NO:		TODAYS DATES	
EMAIL:		DATE OF BIRTH:	
DUE DATE:		NUMBER OF PREGNANCIES	
FAMILY CIRCUMSTANCES (PARTNER / DEPENDANTS):			
NEXT OF KIN CONTACT:			

OCCUPATION:		FT / PT
MEDICATION (PAST AND PRESENT):		

PRESENTING CONDITIONS (REASONS FOR TREATMENT): PREGNANCY INFORMATION: MORNING SICKNESS/ PELVIC PAIN/ BLOOD PRESSURE/ SPOTTING/ ETC
Asked to check back in with GP /Midwife ☐

MEDICAL HISTORY: BLOOD PRESSURE Y/N OPERATIONS Y/N RESPIRATORY Y/N DIGESTION Y/N CIRCULATORY PROBLEMS Y/N NERVOUS SYSTEM Y/N ACCIDENTS, INJURIES, Y/N PREVIOUS PREGNANCY DETAILS Y/N

FAMILY MEDICAL HISTORY:

LIFESTYLE

DIET (TYPICAL DAILY INTAKE, FLUIDS & SUPPLEMENTS):

Exercise:

HOBBIES / RELAXATION:
STRESS LEVELS / WORRIES & FEARS:

DETAILS OF PREVIOUS TREATMENTS:
OTHER COMPLEMENTARY TREATMENTS:

ANY ADDITIONAL INFORMATION:

Outline of agreed treatment plan			
The information used on this consultation sheet is treated with the strictest confidence and is used to ensure that you have the most appropriate treatment possible so please sign to conform you given me all your relevant health information and are happy to have treatment.			
CLIENT SIGNATURE:		DATE:	