



# PHYSICAL FOR PREGNANT WOMEN (Pregnancy History/Prenatal Risks Assessment)



Please provide the information requested below for your patient. This information will be used by staff of the Early Head Start program to provide a comprehensive and individualized prenatal/postpartum program to benefit your patient and her unborn child.

Patient's Name: (PRINT) First _____ Last _____	Patient's Address: Street _____ Apt. # _____ City _____, CA ZIP _____
Phone Number: (      ) _____	Date of Birth: _____

**Date of first prenatal visit:** \_\_\_\_\_ **# of previous pregnancies (including miscarriages):** \_\_\_\_\_

**Have you or any family members experienced Perinatal Depression?**  no  yes

**If yes, explain:** \_\_\_\_\_

**Woman's Current (Prenatal)**

Height: \_\_\_\_\_ inches      Weight: \_\_\_\_\_ lbs.      Measurement Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Hemoglobin: \_\_\_\_\_ and/or Hematocrit: \_\_\_\_\_      Blood Test Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Proof of Pregnancy** (weeks gestation) \_\_\_\_\_      **Due Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Complications experienced during pregnancy:**

- |                                               |                                           |                                          |
|-----------------------------------------------|-------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Swelling             | <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Abdominal Pain  |
| <input type="checkbox"/> Low Birth Weight     | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Uterine Irritability | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Pre-term labor  |
| <input type="checkbox"/> Sickle Cell Anemia   | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Anxiety         |
| <input type="checkbox"/> Stress               | <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> Other: _____    |

**List any current medications/supplements prescribed:**

\_\_\_\_\_

\_\_\_\_\_

**Comments:**

\_\_\_\_\_

\_\_\_\_\_

Print Name of Doctor \_\_\_\_\_ Signature/Official Stamped Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**EHS Staff Only**  
**Date Received:**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_