# Past Pregnancy Questionnaire

**Patient Name: ____________________________ Date of Birth: ________________**

Please fill in as much information as you can remember, if you don't know the answer you can check the [ ] at the end of the question. **Please answer all the questions.**

We may also need to request records from previous providers/ hospitals, if so we will ask you to sign a records release. Please list all previous pregnancies: (full term, pre- term, stillbirths, and miscarriages). If you have had any miscarriages, just note the date, and how many weeks you were. Please also include if you had a D & C. If you need more room, please use a blank sheet of paper.

[ ] Please check this box if this is your first pregnancy.

Date of delivery __________________ [ ] Male [ ] Female [ ]

Baby's weight: ___________________ [ ] How many weeks were you? ___________ [ ]

How long did labor last? ____________ [ ] Vaginal birth [ ] C- section [ ] VBAC [ ]

Who was the delivering doctor/ where did you deliver? _______________________________________________

Did you have any anesthesia or pain medications? __________________________________________None [ ]

List any complications: ______________________________________________________________None [ ]

Date of delivery __________________ [ ] Male [ ] Female [ ]

Baby's weight: ___________________ [ ] How many weeks were you? ___________ [ ]

How long did labor last? ____________ [ ] Vaginal birth [ ] C- section [ ] VBAC [ ]

Who was the delivering doctor/ where did you deliver? _______________________________________________

Did you have any anesthesia or pain medications? __________________________________________None [ ]

List any complications: ______________________________________________________________None [ ]

Date of delivery __________________ [ ] Male [ ] Female [ ]

Baby's weight: ___________________ [ ] How many weeks were you? ___________ [ ]

How long did labor last? ____________ [ ] Vaginal birth [ ] C- section [ ] VBAC [ ]

Who was the delivering doctor/ where did you deliver? _______________________________________________

Did you have any anesthesia or pain medications? __________________________________________None [ ]

List any complications: ______________________________________________________________None [ ]

**Patient Name: ______________________________ Date of Birth: ________________**

Date of delivery _______________ [ ] Male [ ] Female [ ]

Baby's weight: ________________ [ ] How many weeks were you? _________ [ ]

How long did labor last? __________ [ ] Vaginal birth [ ] C- section [ ] VBAC [ ]

Who was the delivering doctor/ where did you deliver? ________________________________________

Did you have any anesthesia or pain medications? ___________________________________None [ ]

List any complications: ____________________________________________________None [ ]

Date of delivery _______________ [ ] Male [ ] Female [ ]

Baby's weight: ________________ [ ] How many weeks were you? _________ [ ]

How long did labor last? __________ [ ] Vaginal birth [ ] C- section [ ] VBAC [ ]

Who was the delivering doctor/ where did you deliver? ________________________________________

Did you have any anesthesia or pain medications? ___________________________________None [ ]

List any complications: ____________________________________________________None [ ]

Date of delivery _______________ [ ] Male [ ] Female [ ]

Baby's weight: ________________ [ ] How many weeks were you? _________ [ ]

How long did labor last? __________ [ ] Vaginal birth [ ] C- section [ ] VBAC [ ]

Who was the delivering doctor/ where did you deliver? ________________________________________

Did you have any anesthesia or pain medications? ___________________________________None [ ]

List any complications: ____________________________________________________None [ ]

Date of delivery _______________ [ ] Male [ ] Female [ ]

Baby's weight: ________________ [ ] How many weeks were you? _________ [ ]

How long did labor last? __________ [ ] Vaginal birth [ ] C- section [ ] VBAC [ ]

Who was the delivering doctor/ where did you deliver? ________________________________________

Did you have any anesthesia or pain medications? ___________________________________None [ ]

List any complications: ____________________________________________________None [ ]