

Name: _____ DOB: _____
 Allergies: _____

Pregnancy Record

No. of Pregnancies: _____		Deliveries: _____		Miscarriages: _____		Abortions: _____			
No.	Mo./Yr.	Hospital	Baby's wt.	Sex	Wks.	Hrs. Labor	Vaginal/ C-section	Complications?	
								Yes	No
								Yes	No
								Yes	No
								Yes	No
								Yes	No
								Yes	No
								Yes	No
								Yes	No

Hospitalizations (excluding pregnancies)

Date	Hospital	Reason and Description

Problem List (for CNM use only)

Date	Problem	Treatment