Prenatal Care Assessment Form

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Contact Number: _____

Medical History

1. Previous pregnancies: _____

2. Any complications? (Yes/No): _____

If yes, please specify: _____

3. Current medications: _____

Current Pregnancy Details

1. Estimated Due Date: _____

2. Current Trimester: _____

3. Symptoms (Nausea, Cravings, etc.): _____

Lifestyle Information

1. Exercise routine: _____

2. Dietary habits: _____

3. Substance use (Alcohol, Tobacco, etc.): _____

Family History

1. Genetic conditions: _____

2. Important family health issues: _____

Provider Notes

_____

Patient Signature

_____ Date: _____