A#_____

FMCC Fertility & Midwifery Care Center

Patient Name:_____ **Date:** _____

Pregnancy History

Total Pregnancies:_____/ **Full Term:**_____/ **Preterm:**_____/ **Miscarriage:**_____/ **Abortion:**_____/ **Ectopic:**_____/ **Multiple:**_____/ **Living:** _____

DATE	HOW FAR ALONG WERE YOU?	HOURS IN LABOR	BIRTH WEIGHT	GENDER	TYPE OF DELIVERY	ANESTHESIA	COMMENTS/ COMPLICATIONS	FACILITY/ PROVIDER

*all remaining health history questions will need to be completed through your patient portal account