Medical Questionnaire – Treatments for Safe Delivery

Name: _____ Date: _____ / _____ / 202__

1. Current week of pregnancy : _____ weeks
   Expected due date : Month_____ / Day_____ / Year _____
2. Course of the current pregnancy and any changes in physical condition since becoming pregnant : _____
3. Fetal position and orientation (If breech presentation, since when)
   _____
4. Current condition
   > Hospitalization during this pregnancy : Yes / No
   > Any bleeding during this pregnancy : Yes / No
   > Currently experiencing bleeding : Yes / No
   > Advised to rest due to threatened preterm labor : Yes / No
   > Problems with the cervix or cervical canal : Yes / No
   > Fetal heartbeat confirmed : Yes / No
   > Singleton or multiple pregnancy : Singleton / Multiple
   > Uterine anomalies, uterine fibroids, low-lying placenta, placenta previa : Yes / No
   > What has your medical provider advised? Have you received permission? : Yes / No
   > Current weight : _____ kg , Pre-pregnancy weight : _____ kg
   > Use of stimulants (alcohol, tobacco) : _____
   > Current physical condition today, such as bowel movements, bleeding, fetal movement, abdominal tightness : _____
5. Previous pregnancy and delivery history ( number of pregnancies, any complications ) : _____
6. Symptoms of concern ( since when, whether after becoming pregnant, current medications: e.g., tocolytics, laxatives, iron supplements, etc.)
   _____
7. Past medical history ( allergies, lifestyle-related diseases, chronic illnesses, gynecological conditions, surgeries ) : _____
8. Medical facility currently attending ( hospital / clinic ) : _____
9. Planned delivery facility : _____
10. Other information
   > Review of Maternal and Child Health Handbook : Yes / No
   > Working hours : _____ to _____ , Time at home : _____ to _____ , Commuting time : _____ hours
   > Planned maternity leave start date : _____ / _____
   > Type of residence : _____
   > Number of people living together : _____