**Health History**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Due Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancy Complications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any medical complications you have had in the past or currently have, as listed below.

|  |  |  |
| --- | --- | --- |
|  | Never had | Previously had/year |
| GBS-Group Beta Strep |  |  |
| Hepatitis A,B or C |  |  |
| HIV/AIDS/HSV (herpes) |  |  |
| Anxiety/Depression |  |  |
| Gonorrhea/Chlamydia/Lyme |  |  |
| Zika Exposure/Syphilis |  |  |

Please list any medications you are currently taking, including over the counter and herbal supplements.

|  |  |
| --- | --- |
| Medications | Supplements |
|  |  |
|  |  |
|  |  |
|  |  |