Obstetric Intake Form

Urban Wellness & Fertility Toronto
416 324 8888

Obstetric Health History

Name: ________________________________ Date: ________________________

What is the main concern for which you are seeking treatment? Please give history of condition.

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What is your due date? ___________________________

How is this pregnancy progressing? Any complications?

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Who is your primary caregiver ? (name, clinic and phone number)

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If you have ever been pregnant:How any times have you been pregnant? _____How many full term babies? ________

Ages of children? __________________________

Please provide some details of your previous deliveries (ie, length, any complications, medical interventions)

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Please be assured that your information is confidential and will be shared only with your practitioners.