

Consultation form- Maternity Supplement

Name:...................................................... Date:

First Visit- Number of weeks Pregnant: EDD:

Obstetric Caregiver: Midwife/GP/Consultant Name:......................................................................

Contact Details......................................................................................................................................

**This pregnancy**

Planned Y/N Naturally conceived Y/N

First Pregnancy Y/N Scan Y/N Ok Y/N

Additional details/ how do you feel about the forthcoming birth? ………………………….......................................................................................................................................

What do you do during a typical day? .....................................................................................................

How do you relax in the evening? ...........................................................................................................

Amniocentesis Y/N GTT Y/N Other Y/N....................................................................

Do you /have you suffered from any of the following Y/N/Prev

|  |  |  |  |
| --- | --- | --- | --- |
| Backache/ injury |  | Varicose veins |  |
| Rib pain |  | DVT \* |  |
| Symphisis pubis |  | Haemorrhoids |  |
| Groin pain |  | Low BP |  |
| Braxton hicks |  | High BP \* |  |
| Vaginal bleeding |  | Oedema |  |
| Morning sickness |  | Panic attacks |  |
| Heartburn |  | Carpel tunnel syndrome |  |
| Placenta praevia \* |  | Sciatica |  |
| Constipation |  | Headaches \* |  |
| Diarrhoea |  | Stretch marks |  |
| Weak pelvic floor |  | Itchy skin |  |
| Cystitis |  | Glaucoma |  |
| Protein/blood/sugar in urine |  | Fatigue |  |
| Palpitations |  | Diabetes \* |  |
| Head or neck injury |  | Mood swings |  |
| Leg pain/ cramps |  | Insomnia |  |

**Previous pregnancies**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 1 | 2 | 3 | 4 |
| Normal pregnancy y/n |  |  |  |  |
| Ailments suffered |  |  |  |  |
| Pre-term/ on-time/ overdue |  |  |  |  |
| Normal delivery y/n |  |  |  |  |
| Induction |  |  |  |  |
| Epidural |  |  |  |  |
| Assisted delivery |  |  |  |  |
| Stitches |  |  |  |  |
| Breast fed |  |  |  |  |
| Post-natal problems |  |  |  |  |
| Miscarriage/ terminations (date) \* |  |  |  |  |
| Briefly explain how you feel about the birth/ what you would change. |  |  |  |  |

Reasons for treatment:...........................................................................................................................

Expectations from treatment:..................................................................................................................

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I understand the treatment I am about to receive.

I am happy for Caroline to proceed with treatment.

Signed:........................................ Print:...........................................

Date:...........................................

How did you hear about us?

Any other comments?

Treatment Notes (please leave blank):

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