

# ANTENATAL HEALTH SCREENING FORM

Name of Adult:			
Address:	Postcode:		
Due Date:			
Telephone number:		Mobile:	
Email address:			
Emergency contact:		Relationship:	
Telephone number:		Mobile:	
Doctors name and contact:			
Midwives name and contact:			

## Medical History

Your instructor will discuss this form with you before your first class. Please be honest as there are guidelines in place for the safety of you and your baby.

Can you swim? / What is your ability level?	Details:
Do you have any special needs?	Details:
Are you taking any medication? :	Details:
Do you have any serious medical conditions? Please tick all that apply.	<input type="checkbox"/> Thrombosis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Condition <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Other:
Other problems?	<input type="checkbox"/> Back or joint pain <input type="checkbox"/> Pubic or groin pain <input type="checkbox"/> Pain on walking <input type="checkbox"/> Recurrent miscarriages
In THIS pregnancy have you had any of the following?	<input type="checkbox"/> Multiple pregnancy (Twins etc) <input type="checkbox"/> Low lying placenta (placenta praevia) <input type="checkbox"/> bleeding or loss of Amniotic fluid <input type="checkbox"/> Early contractions or pre-term labour <input type="checkbox"/> Sensitivity to Chlorine <input type="checkbox"/> Fear of water

**If you answered YES to one or more questions, you must check with your doctor before taking part.**

## ASSUMPTION OF RISK

I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Signature:

Date:

## INSTRUCTOR USE ONLY

Any advice given to client:

Signature: