Galter LifeCenter
The science of feeling better

Pre/Postnatal Health History Form

HEALTH RISK SCREENER			
NAME:			DUE DATE:
ADDRESS:			
HOME PHONE:			WORK PHONE:
AGE:	EMAIL:		OCCUPATION:
PARTNER'S NAME:			ADDRESS:
PHONE #:			OCCUPATION:
DOCTOR/ MIDWIFE:			
PHONE #:			HOSPITAL:
NUMBER & AGES OF CHILDREN AT HOME:			
HOW DID YOU HEAR ABOUT THIS CLASS?			

FOR POSTPARTUM ONLY*

Date of Delivery:					
Type of Delivery:					
Did you have an episiotomy?	☐ YES	☐ NO	Are you breastfeeding?	☐ YES	☐ NO
Are you getting up at night?	☐ YES	☐ NO	Are you napping during the day?	☐ YES	☐ NO
Is there anything about your pregnancy or birth you feel is relevant to your participation in an exercise program?					
Prior Exercise History Includes:					

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HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE PAST OR PRESENT?

Shortness of Breath	☐Yes ☐No	Back Problems or Pain	☐Yes ☐No
Heart Disease	☐Yes ☐No	Knee Problems or Pain	☐Yes ☐No
Chest Pain	☐Yes ☐No	Neck Problems or Pain	☐Yes ☐No
Diabetes	☐Yes ☐No	Arthritis	☐Yes ☐No
Hypoglycemia	☐Yes ☐No	Seizures	☐Yes ☐No
Multiple Births	☐Yes ☐No	Cesarean Birth	☐Yes ☐No
Miscarriage	☐Yes ☐No	Vaginal Bleeding	☐Yes ☐No
Pelvic or Abdominal Cramps	☐Yes ☐No	Vaginal Spotting	☐Yes ☐No
Intrauterine Growth Retardation	☐Yes ☐No	Blood Disorders	☐Yes ☐No
Placenta Previa	☐Yes ☐No	Incompetent Cervix	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Multiple Gestation	☐Yes ☐No
Eating Disorder	☐Yes ☐No	Other:	☐Yes ☐No

If you answered "Yes" to any of the above, please explain:

Is there anything in your medical history that could affect your ability to exercise? Please explain:

Are you taking any medications? If yes, please list them below (Include vitamins and diuretics).

Additional Information:

Do you feel that you know how to relax?
What are your goals for participating in this class?
Would you be interested in: ☐ Pre/postnatal Aqua Exercise ☐Baby & Me Classes ☐ Perinatal Group Fitness