**This form must be returned even if there is no significant medical history as an audit trail**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Name |       | D.o.B. |       | NHS number |       |
| **NO MEDICAL HISTORY (Please put X in the box and return)**  |
| **MEDICAL HISTORY**: (Please include ongoing care at hospital clinic, previous relevant medical history, severity of medical illness etc.)      |
| **CURRENT MEDICATION**:      |
| **MENTAL HEALTH DIFFICULTIES:** (Please specify if taking any medication, treatment plan, psychiatric input or previous puerperal psychosis)      |
| **SUBSTANCE MISUSE (INCLUDING ALCOHOL):** (Please specify if known)      |
| **SAFEGUARDING CHILDREN ISSUES:** (Please include any known social services involvement)      |
| **RELEVANT HISTORY OF PARTNER / FAMILY RELEVANT TO PREGNANCY / PARENTING?** |