MATERNAL HEALTH HISTORY PATIENT QUESTIONNAIRE

Name

Date of Birth (yyyy/mm/dd)

FOR THE HEALTH CARE PROVIDER TO COMPLETE

G	T	P	A	L	**Expected date of birth (EDB)** (yy/mm/dd):	**Gestational Age** (week):	Number of fetuses

EDB Determined by: ❑ Unknown
❑ ART (Assisted reproductive technology) ❑ Last menstrual period ❑ US T1 ❑ US T2 ❑ OB clinical estimate

OBS History: # previous vaginal births: ____ # previous C/S: ____ # previous VBAC's: ____

Losses: Stillbirth(s): ___ Neonatal Death(s): ____ Spontaneous Abortion(s): ____ Therapeutic Abortion(s): ____

Type of conception: ❑ Unknown ❑ Spontaneous ❑ Surrogate
❑ Intra Uterine Insemination (IUI) ❑ IUI with ovulation induction ❑ UI with ovulation induction but no IVF
❑ In vitro fertilization (IVF) ❑ IVF ICSI (Intracytoplasmic sperm Injection) ❑ Ovulation induction but no IVF

Height:	**Weight:** Usual: Present:	**BMI:**

FOR THE WOMAN TO COMPLETE

Please complete this questionnaire and give it to your Health Care Provider. If you are not sure of any answer, check "not sure". You can add details in the "Comments" section. Your nurse will review this form with you when you are admitted to the hospital. Please note, some information from this form is collected for the provincial database.

Check all who cared for you during this pregnancy:
❑ Family doctor ❑ Obstetrician ❑ Midwife ❑ Nurse Practitioner ❑ Other:

What is the name of your doctor/midwife?	What is the name of your **baby** doctor/midwife?

Was your first prenatal visit before 14 weeks (3 1/2 months)? ❑ Yes ❑ No

Language spoken at home: ❑ English ❑ French ❑ Other: _____

DID YOU HAVE ANY OF THE FOLLOWING CONDITIONS BEFORE OR DURING THIS PREGNANCY?

	YES	NO	Not sure	Check all that apply – Comments/Specify
Autoimmune disease				❑ Lupus ❑ Arthritis ❑ Other:
Cancer				❑ Diagnosed prior to pregnancy ❑ Diagnosed in pregnancy Type of cancer: _____ Current treatment:
Heart problems				❑ Congenital heart defect ❑ Congenital heart disease ❑ Pacemaker or implantable defibrillator ❑ Arrhythmias ❑ High blood pressure before pregnancy (pre-existing hypertension) ❑ Require antibiotics before surgery or going to the dentist ❑ Other:

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DID YOU HAVE ANY OF THE FOLLOWING CONDITIONS BEFORE OR DURING THIS PREGNANCY?

	YES	NO	Not sure	Check all that apply – Comments/Specify
Diabetes				❑ Type 1 ❑ Type 2 on oral medication ❑ Type 2 not on insulin ❑ Type 2 on insulin ❑ Gestational diabetes on diet only ❑ Gestational diabetes on insulin
Hormone or gland problems				❑ Hyperthyroidism (High) ❑ Hypothyroidism (Low) ❑ Other:
Stomach or intestinal problems				❑ Colitis ❑ Crohns ❑ Hepatitis ❑ Stomach ulcers ❑ Heartburn ❑ Hiatus hernia ❑ Other:
Genital-urinary problems				❑ Kidney disease: ❑ On dialysis ❑ Bladder infection during this pregnancy ❑ Uterine anomalies (specify): ❑ Fibroids ❑ Other:
Blood problems				❑ Chronic anemia (low iron) ❑ Blood clots (e.g. legs, lungs) ❑ Bleeding disease/problem (e.g. Thrombophilia) ❑ Sickle cell anemia ❑ Received blood products in last 3 months (e.g. Transfusion, Rhogam) ❑ Blood thinners (e.g. Heparin) ❑ Other:
Neurological problems				❑ Epilepsy or seizures ❑ Multiple Sclerosis ❑ Dizziness ❑ Fainting spells ❑ Migraines ❑ Other:
Breathing problems				❑ Asthma ❑ Shortness of breath ❑ Sleep apnea ❑ Previous blood clot in lungs ❑ Use machine to sleep *(If yes, bring machine to hospital)* ❑ Other:
Pain				Describe:
Mental health concerns				❑ Anxiety / panic attacks ❑ Bipolar ❑ Schizophrenia ❑ Previous post partum depression ❑ History of depression ❑ Addiction: _____ ❑ Other: _____ ❑ Currently seeing a psychologist, counsellor or other provider
Did you take medication during your pregnancy?				❑ Antidepressants (SSRIs) (e.g. Prozac, Paxil) ❑ Vitamins ❑ Narcotics (e.g. Morphine, Oxycontin) ❑ Anti-nausea ❑ Amphetamines (e.g. Adderral) ❑ Thyroid ❑ Pain medications ❑ Antibiotics ❑ Herbal/Homeopathy ❑ Other prescription drugs: _____ ❑ Other over the counter drugs: _____ ***Please bring the list of medications with you to the hospital***
Did you take Folic Acid?				❑ Before pregnancy only ❑ During pregnancy only ❑ Both before and during pregnancy

	YES	NO	Not sure	Check all that apply – Comments/Specify
Have you or anyone in your family had serious problems after being given an anesthetic (e.g. Malignant Hyperthermia)?				
Do you have trouble opening your mouth, jaw or moving your neck?				
Do you have personal or religious reasons for refusing any blood product (e.g. Transfusion, Rhogam)?				
Did you smoke during your first 14 weeks of pregnancy?				❑ Less than 10 cigarettes/day ❑ 10-20/day ❑ More than 20/day
Do you currently smoke?				❑ Less than 10 cigarettes/day ❑ 10-20/day ❑ More than 20/day ❑ I would like information about how to stop smoking
Does anyone in your household smoke?				❑ During first 14 weeks ❑ Throughout pregnancy ❑ **At time of admission**
Did you drink any alcohol during your pregnancy?				If yes: On average how much do you drink? Monthly: ❑ Less than1 drink ❑ 1 drink ❑ 2-3 drinks ❑ More than 4 drinks Weekly: ❑ Less than 1 drink ❑ 1 drink ❑ More than 1 drink
Have you ever used drugs and/or other substances during your pregnancy?				❑ Gas/Glue ❑ Marijuana ❑ Cocaine ❑ Hallucinogens ❑ Methadone ❑ Opioids ❑ Other (specify):
Are you currently using drugs or other substances?				❑ Gas/Glue ❑ Marijuana ❑ Cocaine ❑ Hallucinogens ❑ Methadone ❑ Opioids ❑ Alcohol ❑ Other (specify):
Do you believe you have a drug or alcohol problem?				❑ I am currently receiving treatment ❑ I would like information on how to stop
Does your partner have a drug or alcohol problem?				❑ Gas/Glue ❑ Marijuana ❑ Cocaine ❑ Hallucinogens ❑ Methadone ❑ Opioids ❑ Alcohol ❑ Other (specify):

FAMILY AND SOCIAL HISTORY

	YES	NO	Not sure	Check all that apply – Comments/Specify
Have you had any major life changes this year (e.g. change in marital status, move, death of a loved one)?				
Do you generally cope well with stress in your life?				
Is there anything in particular that is worrying you (e.g. financial, relationships, family)?				
Do you have any concerns about being a new parent?				

FAMILY AND SOCIAL HISTORY

	YES	NO	Not sure	Check all that apply – Comments/Specify
Do you have any safety concerns for your children at home?				❑ No other children
Are you ever afraid of your partner or anyone else?				
Have you ever been physically, emotionally or sexually abused by someone?				
Do you have a family member or friend you can turn to for help or advice?				
Will you have help/support when you go home with your baby?				
Would you like a referral to any community services?				
How do you feel about your pregnancy?				
How does your partner feel about your pregnancy?				

BIRTH PLANS AND PREFERENCES

How do you plan to feed your baby?

❑ Breastfeeding ❑ I have breastfed _____ babies in the past ❑ Formula feeding

Do you have any questions or concerns about feeding your baby?

What are your priorities for labour and birth/cesarean birth?

Do you have a written plan? ❑ Yes ❑ No *If yes, please share it with your nurse when admitted. She will return it after reviewing it with you.*

What comfort measures are you intending to use during your labour?

❑ Shower ❑ Tub
❑ Nitrous oxide ❑ Positioning ❑ Massage ❑ Walking ❑ Birthing ball ❑ Music
❑ Sterile water injections ❑ TENS ❑ Narcotics ❑ Epidural ❑ Other:

In preparation for birth, did you access or participate in any of the following? ❑ Prenatal classes

❑ Hospital website ❑ Doula services ❑ Pre-admission information session
❑ Breastfeeding classes ❑ Child and infant CPR course ❑ Birth companion program
❑ Quit smoking program ❑ Nutrition classes ❑ Parenting classes
❑ Other community programs (specify):

Is there any other information/questions you would like to share with your health care provider(s)?

Printed name(s)	Signature	Date (yyyy/mm/dd)	Time
Patient			
Reviewing Nurse			
Reviewing Nurse			