BURNABY MATERNITY CLINIC

FIRST PRENATAL VISIT QUESTIONNAIRE

Please email the form to burnabymaternity@fraserhealth.ca or bring it to your first appointment.

About you

Name: _____

Date of Birth (DD/MM/YYYY):_____ Preferred pronouns: _____

Personal Health Number (PHN):_____ Primary Care Provider: _____

Preferred phone number:_____ Alternate phone number: _____

Home address (including city and postal code)_____

Email:_____ (Optional) I consent to the use of my email for information affecting my care e.g. appointment reminders ☐ Yes ☐ No

Occupation:_____ Hours of work/day: _____

Highest level of education:_____ Ethnicity: _____

Preferred language:_____Do you require a translator at your appointments: _____

Height: _____ Current weight: _____ Pre-pregnancy weight: _____

About your partner (if applicable)

Name: _____

Age:_____ Preferred pronouns: _____

Occupation:_____ Ethnicity: _____

About your current pregnancy

What is important to you for your care during this pregnancy? _____

_____

_____

Is this an IVF (in vitro fertilization) pregnancy?	□ NO	□ YES	
Any spotting or bleeding?	□ NO	□ YES	At how many weeks? _____
Any nausea?	□ NO	□ YES	Is it getting better, worse, or staying the same? _____
Any infections or fevers?	□ NO	□ YES	Please describe: _____ _____
When was the first day of your last menstrual period?			
Is your menstrual cycle regular?	□ NO	□ YES	How long is your cycle? _____ days
Have you had any ultrasounds for this pregnancy?	□ NO	Have you planned one? □ YES, on_____(date) at_____(location) □ NO	
	□ YES	On_____(date), at_____(weeks) at_____(location)	
Genetic testing is available to screen for syndromes (such as Down syndrome). Are you interested in genetic testing?	□ NO	□ YES	

Your pregnancy history

If this is your first pregnancy, skip this section. If this is <u>not</u> your first pregnancy, please list your previous pregnancies:

Previous pregnancy loss due to miscarriage, stillbirth, or abortion:

Year	How many weeks?	What surgery or medication did you need, if any?

Previous births:

Please provide as much detail as you can.

Date (DD/MM/YY):		Country:	
Name of hospital or birthing centre:			
Weeks pregnant:	Hours of labour:	☐ C-section ☐ Vaginal delivery	☐ Forceps ☐ Vacuum
Complications:			
Baby's sex: ☐ Male	☐ Female	Baby's birth weight:	

Date (DD/MM/YY):		Country:	
Name of hospital or birthing centre:			
Weeks pregnant:	Hours of labour:	☐ C-section ☐ Vaginal delivery	☐ Forceps ☐ Vacuum
Complications:			
Baby's sex: ☐ Male	☐ Female	Baby's birth weight:	

Date (DD/MM/YY):		Country:	
Name of hospital or birthing centre:			
Weeks pregnant:	Hours of labour:	☐ C-section ☐ Vaginal delivery	☐ Forceps ☐ Vacuum
Complications:			
Baby's sex: ☐ Male	☐ Female	Baby's birth weight:	

Date (DD/MM/YY):		Country:	
Name of hospital or birthing centre:			
Weeks pregnant:	Hours of labour:	☐ C-section ☐ Vaginal delivery	☐ Forceps ☐ Vacuum
Complications:			
Baby's sex: ☐ Male	☐ Female	Baby's birth weight:	

Were there any unusual circumstances that happened during your previous births?
For example: fast delivery, heavy bleeding, retained placenta, shoulder dystocia, breech position

____

____

Your medical history

Do you have any medication allergies?	□ NO	□ YES	Drug(s): _____ _____ Your reaction(s): _____ _____
Are you taking any medicines? Please include any prenatal vitamins and over the counter medications.	□ NO	□ YES	Please list all medicines and doses here:

Have you ever had:

Surgery? *For example: Therapeutic abortions, breast augmentation, other plastic surgery, wisdom teeth removal*	□ NO	□ YES	When were the surgeries, what surgeries, and why**?**
Problems with anesthesia during surgery?	□ NO	□ YES	Please describe:
Procedures or concerns involving the uterus, ovaries or cervix? *For example: Abnormal pap smears, cone biopsy*	□ NO	□ YES	Please describe:
When was your last pap smear (DD/MM/YY)?			
Heart or lung problems? *For example: High blood pressure, asthma*	□ NO	□ YES	Please describe:
Back or spine problems?	□ NO	□ YES	Please describe:
Serious infections or sexually transmitted infections (STIs) *For example: Hepatitis, herpes*	□ NO	□ YES	Please describe:
Chickenpox?	□ NO	□ YES	Please describe:
Blood concerns? *For example: Blood clots in your legs or lungs, bleeding disorders*	□ NO	□ YES	Please describe:
Stomach problems? *For example: Irritable bowel syndrome, acid reflux*	□ NO	□ YES	Please describe:
Bladder or kidney problems?	□ NO	□ YES	Please describe:
Thyroid problems or diabetes?	□ NO	□ YES	Please describe:
Neurological concerns? *For example: Seizures, headaches*	□ NO	□ YES	Please describe:

Mental health concerns? *For example: Anxiety, depression, bipolar disorder, psychosis*	□ NO	□ YES	Please list any medications or hospital admissions:

Do you have any other health concerns not listed above?_____

_____

Your family history

Do you have a family history of:

Pregnancy complications? *For example: High blood pressure, diabetes*	□ NO	□ YES	Which relatives? Please describe complications:
Birth defects or genetic conditions?	□ NO	□ YES	Please describe:
Heart disease? *For example: Heart attacks, bypass surgery, strokes, heart failure*	□ NO	□ YES	Which relatives?
High blood pressure?	□ NO	□ YES	Which relatives?
Diabetes?	□ NO	□ YES	Which relatives?
Mental health concerns? *For example: Depression, anxiety*	□ NO	□ YES	Which relatives?
Problematic alcohol use?	□ NO	□ YES	Which relatives?
Drug addiction?	□ NO	□ YES	Which relatives?
Clotting disorders? *For example: Blood clots in the legs or lungs*	□ NO	□ YES	Which relatives?
Bleeding disorders?	□ NO	□ YES	Which relatives?

Your lifestyle and social history

Are you on a special diet? *For example: Vegan, vegetarian*	□ NO	□ YES	Please describe:

Do you exercise regularly?	□ NO	□ YES	Please describe the exercise you do, and how often:
Do you drink alcohol?	□ NO	□ YES	How many drinks per week before pregnancy? _____ How many drinks during during pregnancy? _____ When was your last drink? _____
Do you smoke cigarettes or use a vape?	□ NO	□ YES	How many cigarettes per day before pregnancy? _____ During pregnancy? _____ How often did you vape each day before pregnancy? _____ During pregnancy _____ Quit day (if applicable): _____
Are you around secondhand smoke?	□ NO	□ YES	From who? _____
Do you smoke marijuana?	_ NO	YES	
Do you use any illegal drugs? (e.g. meth, cocaine, heroin)	□ NO	□ YES	Please describe:
Do you have concerns about, or problems with, finances or housing? *For example: Difficulty paying bills or rent, receiving social assistance*	□ NO	□ YES	Please describe:
Do you have a stable support system to help you throughout this pregnancy and when caring for your newborn?	□ NO	□ YES	Please describe:

Tell us more about the care you want

Please list any concerns for this pregnancy, or general questions, that you would like us to talk about on your first visit.

On behalf of the team at the Burnaby Maternity Clinic,
we welcome you and look forward to caring for your pregnancy