

# **FIRST VISIT QUESTIONNAIRE - PORT MOODY MATERNITY CLINIC**

200-205 Newport Drive, Port Moody, BC, V3H 50 Tel: 604 949 7248 Fax: 604 949 7249

Please fax or email this form to [forms.pmmc@gmail.com](mailto:forms.pmmc@gmail.com) or drop it off before your first prenatal appointment

## **PERSONAL HISTORY:**

Name: \_\_\_\_\_ PHN: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: (DD/MM/YY) \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Partner's name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Prepregnant weight: \_\_\_\_\_

Allergies and reaction: \_\_\_\_\_

## **Medications/ Herbals and doses:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

First day of last menstrual period: (DD/MM/YY) \_\_\_\_\_ Menstrual cycle length: \_\_\_\_\_ days

Birth control used: \_\_\_\_\_ When did you stop? \_\_\_\_\_

1<sup>st</sup> Ultrasound date: \_\_\_\_\_ Where: \_\_\_\_\_

## **OBSTETRICAL HISTORY**

Previous pregnancies, losses and terminations:

Year	Hospital/Country	# Weeks	Hrs. of labour	Type of delivery	Complications	M/F	Wt.

NAME: \_\_\_\_\_

Were there any complications of your previous pregnancies? (breech, postpartum bleed, retained placenta, shoulder dystocia, rapid delivery, birth defects, etc.) \_\_\_\_\_

---

---

**PRESENT PREGNANCY:**

IVF:  No  Yes      **Any bleeding:**  No  Yes When? \_\_\_\_ weeks

**Nausea/vomiting:**  No  Yes mild moderate severe      **Medication?** \_\_\_\_\_

**Infections / Fevers:** \_\_\_\_\_      **Other:** \_\_\_\_\_

**FAMILY HISTORY:**

<b>Heart Disease</b> <input type="radio"/> Yes <input type="radio"/> No (heart attacks, bypass surgery, stroke, heart failure) Which relative?	<b>High Blood Pressure</b> <input type="radio"/> Yes <input type="radio"/> No Which relatives?
<b>Diabetes</b> <input type="radio"/> Yes <input type="radio"/> No Which relatives?	<b>Depression or Psychiatric Problems</b> <input type="radio"/> Yes <input type="radio"/> No Which relatives?
<b>Alcohol Abuse</b> <input type="radio"/> Yes <input type="radio"/> No Which relatives?	<b>Drug Abuse</b> <input type="radio"/> Yes <input type="radio"/> No Which relatives?
<b>Blood clots (leg, lung, brain)</b> <input type="radio"/> Yes <input type="radio"/> No Or clotting disorder. Which relatives?	<b>Bleeding disorder</b> <input type="radio"/> Yes <input type="radio"/> No Which relatives?

**PAST MEDICAL HISTORY:**

NAME: \_\_\_\_\_

<b>Surgery</b> <input type="radio"/> Yes <input type="radio"/> No (Include therapeutic abortions, wisdom teeth, breast surgery, etc. and where)	<b>Uterine or cervical procedures</b> <input type="radio"/> Yes <input type="radio"/> No (abnormal PAP, colposcopy, other)
<b>Anesthetic</b> <input type="radio"/> Yes <input type="radio"/> No (general or local anesthetic)	<b>Asthma Medication?</b> <input type="radio"/> Yes <input type="radio"/> No
<b>Heart / Lung disease</b> <input type="radio"/> Yes <input type="radio"/> No	<b>Serious infections or sexually transmitted disease</b> (Herpes, Chlamydia, Gonorrhea) <input type="radio"/> Yes <input type="radio"/> No
<b>Soft tissue injuries or back problems</b> <input type="radio"/> Yes <input type="radio"/> No	<b>Blood clots in legs, arms, brain</b> <input type="radio"/> Yes <input type="radio"/> No
<b>Chicken pox</b> <input type="radio"/> Yes <input type="radio"/> No	<b>Stomach problem</b> <input type="radio"/> Yes <input type="radio"/> No (irritable bowel, ulcer, constipation)
<b>High blood pressure</b> <input type="radio"/> Yes <input type="radio"/> No (Medications)	<b>Thyroid or Diabetes problem</b> <input type="radio"/> Yes <input type="radio"/> No (Medications, Surgery)  <b>Diabetes in pregnancy</b> <input type="radio"/> Yes <input type="radio"/> No (Insulin?)
<b>Bladder or kidney problem</b> <input type="radio"/> Yes <input type="radio"/> No (Bladder infections, kidney stones)	<b>Seizure or nerve problem</b> <input type="radio"/> Yes <input type="radio"/> No (Epilepsy, migraines, medications)
<b>Mental illness</b> <input type="radio"/> Yes <input type="radio"/> No Anxiety or panic attacks <input type="radio"/> Yes <input type="radio"/> No Depression <input type="radio"/> Yes <input type="radio"/> No Bipolar Disorder <input type="radio"/> Yes <input type="radio"/> No Postpartum Depression <input type="radio"/> Yes <input type="radio"/> No MEDICATIONS:	<b>Other known health issues:</b>

**LIFESTYLE AND SOCIAL HISTORY:**

**NAME:** \_\_\_\_\_

Vegetarian or special diet?  **Yes**  **No** Diet restrictions: \_\_\_\_\_

Folic acid?  **Yes**  **No** When did you start? \_\_\_\_\_

Over the counter drugs/vitamins?  **Yes**  **No** Name? \_\_\_\_\_

Alcohol  **Yes**  **No** Before pregnancy/week \_\_\_\_\_

Binge drink  **Yes**  **No** Currently / week \_\_\_\_\_

Any social drug use or abuse  **Yes**  **No**

Marijuana  Heroin  Cocaine  Methadone  Crystal Meth  Ecstasy

Prescription medications: \_\_\_\_\_

Cigarettes/day: \_\_\_\_\_ before pregnancy; \_\_\_\_\_ currently Vaping: \_\_\_\_\_ mg per day

Any problems with finances or housing?  **Yes**  **No** \_\_\_\_\_

Needing or on social assistance? EI?  **Yes**  **No** \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Hours/week: \_\_\_\_\_ Shift work:  **Yes**  **No**