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 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? _____

1st 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:

Heart Disease ○ **Yes** ○ **No** (heart attacks, bypass surgery, stroke, heart failure) Which relative?	**High Blood Pressure** ○ **Yes** ○ **No** Which relatives?
Diabetes ○ **Yes** ○ **No** Which relatives?	**Depression or Psychiatric Problems** ○ **Yes** ○ **No** Which relatives?
Alcohol Abuse ○ **Yes** ○ **No** Which relatives?	**Drug Abuse** ○ **Yes** ○ **No** Which relatives?
Blood clots (leg, lung, brain) ○ **Yes** ○ **No** Or clotting disorder. Which relatives?	**Bleeding disorder** ○ **Yes** ○ **No** Which relatives?

PAST MEDICAL HISTORY: **NAME: _____**

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

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**