Pacific Maternity Group

Questionnaire

Congratulations on your pregnancy!

We're pleased you have chosen Pacific Maternity Group for your maternity care.
To assist us in providing the best care for you, it is very helpful for us to gather basic information about you and your health, as well as some information on this pregnancy and previous pregnancies.

Please fill out this form before your first appointment and bring your completed questionnaire with you to your first appointment. At your first visit, your doctor will review this health information, go over your questions, and make plans for follow up including a complete physical early in your pregnancy.

Your name _____ Partner's name_____

Your age _____ Partner's age_____

Your ethnic background _____ Partner's ethnic background_____

Your occupation _____ Partner's occupation _____

Name of family doctor _____

Medications:
Please list any medications, including vitamins and supplements, which you are currently taking or have taken since becoming pregnant:

_____
_____
_____

Allergies:
Please list any allergies and the reaction you had to each:

_____
_____
_____

Have you been pregnant before? □ Yes □ No If so, how many times? _____

How many children do you have? _____

We'll be asking you more questions about your previous pregnancies when we see you in person. If there's anything you want to make sure we discuss at the visit regarding a previous pregnancy, please feel free to make some notes in the space below:

_____

_____

_____

When was the first day of your **last menstrual period?** _____

Did you have In Vitro Fertilization (IVF) to get pregnant?	□ Yes □ No
Have you had any bleeding in this pregnancy?	□ Yes □ No
Are you nauseated?	□ Yes □ No
Are you vomiting more than once a day?	□ Yes □ No
Have you had any infections in the pregnancy?	□ Yes □ No
Have you had any other complications or problems in this pregnancy?	□ Yes □ No
Have you had your flu shot?	□ Yes □ No

When was your last pap smear? _____ Any history of abnormal paps? _____

Please give details if you've had any of the problems listed above, or anything else you think we should know about this pregnancy:

_____

_____

Your medical history:

Have you ever had surgery for any reason?	□ Yes □ No
Have you ever had a problem when put to sleep for surgery?	□ Yes □ No
Have you ever had any procedures on your uterus or your cervix?	□ Yes □ No
Do you have any heart or lung problems?	□ Yes □ No
Have you ever had herpes or other sexual infections?	□ Yes □ No

If yes, which one(s)? _____

Have you had chicken pox?	□ Yes □ No
Have you ever had a blood clot in your leg or a bleeding/clotting disorder?	□ Yes □ No
Do you have high blood pressure?	□ Yes □ No
Do you have any problems with your stomach or bowels?	□ Yes □ No
Do you have any kidney or bladder problems?	□ Yes □ No
Do you have diabetes or thyroid problems?	□ Yes □ No
Have you ever had a seizure or other neurological problem?	□ Yes □ No
Have you ever had depression, anxiety or manic-depression?	□ Yes □ No

Have you ever struggled with your mood after a pregnancy? □ Yes □ No

Have you ever had an eating disorder (anorexia, bulimia, overeating)? □ Yes □ No

Are there any other problems you've had with your health? □ Yes □ No

Please give more details if you've had any of the above problems with your health:

_____

_____

_____

In your family, does anyone have any of the following problems?

Babies or children with heart disease? □ Yes □ No

High blood pressure? □ Yes □ No

Diabetes? □ Yes □ No

Depression or mental health problems? □ Yes □ No

Alcohol or drug abuse? □ Yes □ No

Blood clot in the legs (DVT) or bleeding/clotting problem? □ Yes □ No

Have any babies in your family or your partner's family been born with a birth defect or genetic problem, or died when they were a baby? □ Yes □ No

Please give details for any of the above issues that run in your family:

_____

_____

_____

Lifestyle history:

Please only fill in this section if you feel comfortable doing so. If there are sensitive issues for you that you would prefer to just discuss in person, we would be happy to talk with you about them.

Before you knew you were pregnant, did you smoke cigarettes? □ Yes □ No

If yes, how many cigs/day? _____

How much do you smoke now? _____

Does your partner smoke? □ Yes □ No

Before you knew you were pregnant,
how many drinks of alcohol would you drink in a week? _____

How many drinks/week now? _____

Before you knew you were pregnant, were you using any drugs? □ Yes □ No

If yes, which drugs were you using? _____

How often were you using this/these drugs? _____

Are you still using this/these drugs? If so, how often? _____

Are you having any trouble finding housing or struggling financially? □ Yes □ No

If yes, we'll be get more details from you during our visit

Is there anything we should know about your home situation that would help us to provide better care for you? Are there any safety concerns for you and/or your baby or other children at home?

□ Yes, there are issues I need to discuss with you □ No, I don't have any concerns

Questions:

Please write down your questions below.
We will cover as many of them as we are able in the first visit, and if more time is needed, we will book another appointment to review the rest of your questions:

1. _____
_____
2. _____
_____
3. _____
_____
4. _____
_____
5. _____
_____

Congratulations again on your pregnancy!