Pacific Maternity Clinic

First Prenatal Visit Questionnaire

Please complete the form and email or drop it off at our office at least **48 hours BEFORE** your first appointment. If we do not receive the completed form prior to your appointment, your visit will be cancelled. Please email the completed form to **one** of the following depending on your provider:

fraser@pacificmedicalvancouver.com (Drs. Hippola, Chen, Fenn)

kingsway@pacificmedicalvancouver.com (Drs. Lusina, Amarsi)

grandview@pacificmedicalvancouver.com (Dr. Tong)

The information on this form will be shared with your health care providers so we can provide optimal care throughout your pregnancy. Having a baby usually means a lot of changes in you and your family's life. You may want to share some of these changes with your providers. They can help you manage these changes; however, we understand that you may be nervous or uncomfortable to talk about these changes with them. Just remember that we are here to help. There is no "best" answer to any of the following questions. Please answer all the questions in the best way you can.

About you

Name:

Last name at birth:

Preferred name/pronouns:

Email: (optional) I consent to the use of my email for information affecting my care ie. appointment reminders ☐yes ☐no

Primary care provider:

Date of birth (dd/mm/yyyy):

Preferred language:

Relationship status:

☐Married
☐Living together
☐Single
☐Separated
☐Divorced
☐Widowed

Highest level of education completed:

☐Less than high school
☐High school completed
☐Trade/business school
☐College/university
☐Other? _____

Do you identify as Indigenous?

☐Yes
☐No

Citizenship

☐Canadian Citizen
☐Landed immigrant
☐Refugee

Occupation: _____

☐Employed
☐Full-time ☐Part-time
☐Self-employed
☐Full-time ☐Part-time
☐Student
☐Unemployed
☐Other? _____

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About your partner (if applicable)

Name:

Preferred pronouns:

Age:

Occupation:

Biological father/donor

☐ Same as partner

☐ Other: (name) _____

Age:

Ethnicity:

Your medical history

Allergies: _____ ☐ None

Medications (please include prenatal vitamins and over the counter medications):

☐ Prenatal vitamins

☐ Folic acid

Other (list the name and dose):

_____

_____

_____

When was the first day of your last menstrual cycle? (dd/mm/yyyy):

Your height: ___cm Current weight: ___kg Pre-pregnancy weight: ___kg

When was your last pap smear (dd/mm/yyyy):

Your pregnancy history

If this is your first pregnancy, please skip this section. If this is not your first pregnancy, please list your previous pregnancies and complete the following section:

Have you ever had the following in your previous pregnancies?

☐ Fast delivery

☐ Heavy bleeding

☐ Retained placenta

☐ High blood pressure

☐ Diabetes

☐ Seizures

☐ Shoulder dystocia

☐ Breech position

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

Year	Weeks pregnant	What surgery or medication did you need if any?

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Previous births:

Date (mm/yyyy)	Hospital/ birthing centre	Weeks pregnant	Hours of labour	Mode of delivery	Complications	Sex	Birth-weight (g)	Breastfed	Child's present health
				☐C-section ☐Vaginal delivery ☐Forceps ☐Vacuum		☐Female ☐Male		☐yes ☐no	☐Healthy ☐Other: __________ __________
				☐C-section ☐Vaginal delivery ☐Forceps ☐Vacuum		☐Female ☐Male			☐Healthy ☐Other: __________ __________
				☐C-section ☐Vaginal delivery ☐Forceps ☐Vacuum		☐Female ☐Male			☐Healthy ☐Other: __________ __________
				☐C-section ☐Vaginal delivery ☐Forceps ☐Vacuum		☐Female ☐Male			☐Healthy ☐Other: __________ __________

About your pregnancy

	No	Yes (specify)
Is this an in vitro fertilization pregnancy?	☐	☐ ________________________
Any spotting or bleeding?	☐	☐ ________________________
Any nausea?	☐	☐ ________________________
Have you/your partner traveled recently?	☐	☐ ________________________
Any infections or fevers?	☐	☐ ________________________
Have you had any ultrasounds this pregnancy?	☐	☐ ________________________
Genetic testing is available to screen for syndromes (ie. Down syndrome). Are you interested in genetic testing?	☐	☐ ________________________

Your medical history

Have **you** ever had:	No	Yes (specify)
Surgery or dental procedures?	☐	☐ ________________________
Problems with anesthesia during surgery?	☐	☐ ________________________

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Neurologic concerns ie. seizures, headaches, tingling?	☐	☐	_____
Heart or lung problems ie. asthma, inhalers/puffers, high blood pressure, arrhythmia?	☐	☐	_____
Stomach problems ie. acid reflux, irritable bowel syndrome?	☐	☐	_____
Procedures or concerns involving your uterus, ovaries or cervix ie. abnormal pap smears, cone biopsy, fibroid?	☐	☐	_____
Blood concerns ie. blood clots, bleeding disorders, anemia?	☐	☐	_____
Thyroid problems or diabetes?	☐	☐	_____
Mental health concerns ie. anxiety, depression, bipolar disorder, eating disorder, postpartum depression?	☐	☐	_____
Infections (childhood and adulthood) ie. chicken pox, herpes simplex virus, syphilis?	☐	☐	_____

Immunizations:
☐ Flu (dd/mm/yyyy)
☐ Tdap (dd/mm/yyyy)
☐ COVID-19 (dd/mm/yyyy) x
☐ Other: _____

Your family history

Do you have a **family history** (first degree relative) of:	No	Yes (specify)
Anesthetic complications?	☐	☐ _____
High blood pressure?	☐	☐ _____
Clotting disorders ie. blood clot in legs or lungs?	☐	☐ _____
Diabetes?	☐	☐ _____
Mental health concerns?	☐	☐ _____
Substance use ie. alcohol, recreational drugs?	☐	☐ _____
Genetic conditions?	☐	☐ _____

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Your lifestyle and social history

Are you on a special diet ie. vegan, vegetarian? No ☐ Yes ☐ (specify)_____

I usually exercise (minutes/week)… (can include walking, running, strength training, swimming, hiking, yoga – anything that gets your heart rate up)	0	30-60	60-120	120+
	☐	☐	☐	☐

The following information allows us to provide the best care that is suited to your needs. Your answers are confidential and will be kept private. If you would prefer not to answer, you may leave it blank.

During the last year, I was unable to pay for:	No	Yes (please specify if you would like)
A safe place to live	☐	☐ _____
Enough food	☐	☐ _____
Heat/electricity	☐	☐ _____
Telephone	☐	☐ _____
Transportation	☐	☐ _____
Child care	☐	☐ _____
Dental care	☐	☐ _____

I have:		
Lived in a stressful place	☐	☐ _____
Felt unsafe at home	☐	☐ _____
Felt afraid or threatened by my partner	☐	☐ _____
Been emotionally or physically abused by my partner	☐	☐ _____

I have…	Always.	Most times.	Sometimes.	Rarely.	Never.
Friend(s) that support me	☐	☐	☐	☐	☐
Family that supports me	☐	☐	☐	☐	☐
A spouse/partner that supports me	☐	☐	☐	☐	☐

When I…		3 months before pregnancy	During pregnancy
Drink alcohol, I usually have:	# drinks/day	_____	_____
	# drinks/ week	_____	_____
Smoke cigarettes, I usually have:	# cigarettes/day	_____	_____
Use other substances:	# times/month	_____	_____

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What substances do you use (if any): ☐ Opioids ☐ IV drugs ☐ Methamphetamine ☐ Cocaine ☐ Prescription drugs ☐ Other:		
Are you exposed to second hand smoke? Do you use cannabis?	No ☐ Yes ☐ No ☐ Yes ☐	No ☐ Yes ☐ No ☐ Yes ☐

Questions/concerns:

Do you have any specific fears or concerns around your pregnancy?

What questions do you have that you'd like addressed during the first visit?

What other information or help would you like?

On behalf of the team at the Family Practice Maternity Service, we welcome you and look forward to caring your pregnancy.