Prenatal Patient History

Date: ___________________

Patient's Information

Last name:______________________First Name:_____________________Middle Name: ____________
Birthdate (dd-mmm-yyyy):____Ethnicity:_________________
Healthcare #:__________________________Province:_____________________________________
Address:____Postal Code:___________________
Telephone (home):_____________________(cell):____
Occupation:____
Place of work/Employer:____________________________Telephone (work):______________________

Father's Information

Name:____
Birthdate (dd-mmm-yyyy):____
Ethnicity:____
Occupation:____

Pregnancy Information

What was the first day of your last period?______________ Due date?:___________________________
How long are your menstrual cycles normally (e.g. 28 days)?________________________________
Was this a planned pregnancy?____
What was the last form of birth control you used, and when did you last use it?_____________________
____
Did you receive any fertility treatments to get pregnant?____

Past Pregnancy History

Pregnancies: _____ # Vaginal births: _____ # C/sections: _______
Miscarriages: _____ # Therapeutic abortions:_____

Please complete the following information on all previous pregnancies (if applicable):

Birth date	# of weeks pregnant	Hours in labour	Delivery type (abortion; miscarriage; vaginal; forceps; vacuum; C-section)	Any complications?	Sex	Birth weight	Child's name

(please continue on the back if there are more pregnancies)

Allergies:

Do you have allergies to any medication?
If so, explain:____
Do you have any other allergies?
If so, explain:____

Medications:

Are you taking prenatal vitamins?____
Are you taking any prescription medication?____
Have you stopped taking any medication recently?_______________________________________
Are you taking over the counter or herbal medications?__________________________________

Past Medical History

Please list ALL surgeries:____

____

Have you ever had any of the following (please circle)?

Asthma	Autoimmune diseases (Rheumatoid Arthritis, Lupus, etc)
Bleeding/Clotting disorder/ DVT	Heart condition
High blood pressure	Diabetes
Thyroid disease	Gastrointestinal disease
Epilepsy	Kidney/ bladder disorder
Uterus/ovary/vaginal disorder	Hepatitis/ liver disease
HIV/AIDS	Sexually transmitted infection (incl chlamydia, herpes, HPV)
Tuberculosis	Chicken pox
Mental illness	Depression/ anxiety
Problems with anaesthetic	Blood transfusions
Migraines	Abnormal Pap test

Other illnesses:____

Family history

Has anyone in your family ever had problems with the following?

Diabetes	Twins or Triplets
Heart Disease	Childbirth complications
High Blood Pressure	

Other:____

Has anyone in either your or the father's family had problems with the following?

Hereditary Disease (eg Cystic fibrosis, etc)

Birth Defects (cleft lip, club foot, etc.)

Mental illness/ Depression/ Bipolar disease

Other:____

Life Style/ Social History

Marital Status (circle)**:** Single Married Common-law Divorced Widowed

Do you currently:	**Yes**	**No**	**If yes:**
Smoke?	□	□	# cigarettes per day?__________________________
Drink alcohol?	□	□	# drinks per week?___________________________
Take street drugs?	□	□	# times per week?____________________________

Have you ever used injection drugs? Yes No

Miscellaneous

Do you have a cat?____

Is there anything in your home or work environment that could be hazardous to you or the pregnancy?___

____

____

Are you experiencing any verbal, financial, emotional or physical abuse?_____________________

____