Burnaby Maternity Clinic

First Prenatal Visit Questionnaire

Please email the form to burnabymaternity@fraserhealth.ca or bring it to your first appointment.

About you

Name: _____

Date of Birth (DD/MM/YYYY): _____ Preferred pronouns: _____
e.g. She/her, he/him, they/them

Personal Health Number (PHN): _____ Family Doctor/Nurse Practioner: _____

Preferred phone number: _____ Alternate phone number: _____

Home address (including city and postal code): _____

Email: _____ (Optional) I consent to the use of my email for information affecting my care: e.g. appointment reminders ☐ No ☐ Yes

Occupation: _____ Hours of work/day: _____

Highest level of education: _____ Ethnicity: _____

Preferred language: _____ Do you require a translator at your appointments? _____

About your partner (if applicable)

Name: _____ Relationship status (e.g. Married, Common-Law): _____

Age: _____ Preferred pronouns: _____
e.g. She/her, he/him, they/them

Occupation: _____ Ethnicity: _____

Your medical history

Do you have any medication allergies? ☐ No ☐ Yes Drug(s): _____

Reaction(s): _____

What medicines are you currently taking? Please include any prenatal vitamins and over the counter medications.

Was the pregnancy planned? ☐ No ☐ Yes

Did you take any folic acid (e.g. prenatal vitamins) before the pregnancy? ☐ No ☐ Yes

Please list any special beliefs/practices (e.g. Jehovah's Witness, refusal of blood products, etc.):*

*Note: all patients *must* be comfortable with both male and female providers for their pregnancy and delivery.

Previous births:

If this is your first pregnancy, skip this section. If this is not your first pregnancy, please list your previous births in as much detail as possible:

Date (DD/MM/YY):		City/Country:
Name of hospital or birthing centre:		
Weeks pregnant:	Hours of labour:	☐ C-section ☐ Forceps ☐ Vaginal delivery ☐ Vacuum
Complications:		
Baby's sex: ☐ Male	☐ Female	Baby's birth weight (in g or kg):

Date (DD/MM/YY):		City/Country:
Name of hospital or birthing centre:		
Weeks pregnant:	Hours of labour:	☐ C-section ☐ Forceps ☐ Vaginal delivery ☐ Vacuum
Complications:		
Baby's sex: ☐ Male	☐ Female	Baby's birth weight (in g or kg):

Date (DD/MM/YY):		City/Country:
Name of hospital or birthing centre:		
Weeks pregnant:	Hours of labour:	☐ C-section ☐ Forceps ☐ Vaginal delivery ☐ Vacuum
Complications:		
Baby's sex: ☐ Male	☐ Female	Baby's birth weight (in g or kg):

Date (DD/MM/YY):		City/Country:
Name of hospital or birthing centre:		
Weeks pregnant:	Hours of labour:	☐ C-section ☐ Forceps ☐ Vaginal delivery ☐ Vacuum
Complications:		
Baby's sex: ☐ Male	☐ Female	Baby's birth weight (in g or kg):

Were there any unusual circumstances that happened during your previous births?
For example: fast delivery, heavy bleeding, retained placenta, shoulder dystocia, breech position

____

____

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

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

Year	How many weeks?	What medications or surgery were required, if any?

About your current pregnancy

Is this an IVF (in vitro fertilization) pregnancy?	☐ No	☐ Yes Please describe:	
Any spotting or bleeding?	☐ No	☐ Yes	At how many weeks?
Any nausea?	☐ No	☐ Yes	Is it getting better, worse, or staying the same? What treatments/medications have you tried?
Have you or your partner travelled out of the country in the pregnancy?	☐ No	☐ Yes	Which countries?
Any infections/rashes/fevers?	☐ No	☐ Yes	Please describe: _____
When was the first day of your last menstrual period? DD/MM/YYYY			
Is your menstrual cycle regular?	☐ No	☐ Yes	How often do you get your period? Every _____ days
Have you had any ultrasounds for this pregnancy?	☐ No	Have you planned one? ☐ Yes, on _____(date) at _____ (location) ☐ No	
	☐ Yes	On_____(date), at_____(weeks) at_____(location)	
Genetic testing is available to screen for syndromes (such as Down syndrome). Are you interested in genetic testing*?	☐ No	☐ Yes	

Your Family History

Do you have a family history of (mainly focusing on the birthing parent / mother):

Problems with general anesthesia? *For example: malignant hyperthermia*	☐ No	☐ Yes	Which relatives? Please describe (e.g. father, maternal grandfather, paternal uncle, etc.):
High blood pressure (hypertension)?	☐ No	☐ Yes	Which relatives, please describe:
Clotting problems *For example: Strokes, DVTs, pulmonary embolism*	☐ No	☐ Yes	Which relatives, please describe:
Diabetes (including gestational diabetes)?	☐ No	☐ Yes	Which relatives, please describe:
Mental health concerns? *For example: Depression, anxiety*	☐ No	☐ Yes	Which relatives, please describe:
Substance use disorders? For example: Opioid use disorder, alcohol use disorder	☐ No	☐ Yes	Which relatives, please describe:
Birth defects / inherited conditions? *For example: tay-sachs, sickle cell, heart defects, cystic fibrosis, G6PD*	Mother / Birthing parent		Please describe:
	Biological father / donor		Please describe:
Pregnancy complications? *For example: High blood pressure, pre-eclampsia, gestational diabetes*	☐ No	☐ Yes	Which relatives, please describe:

Your Past Medical History

Height (cm): _____ Current weight (kg): _____ Pre-pregnancy weight (kg): _____

Have you ever had:

Surgery? *For example: Therapeutic abortions, breast augmentation, other plastic surgery, wisdom teeth removal*	☐ No	☐ Yes	When were the surgeries, what surgeries, and why?
Problems with anesthesia in surgery?	☐ No	☐ Yes	Please describe:
Procedures or concerns with the uterus, ovaries or cervix? *For example: Abnormal pap tests, cone biopsy*	☐ No	☐ Yes	Please describe:
When was your last pap test (DD/MM/YY)?			
Heart or lung problems? *For example: high blood pressure, asthma*	☐ No	☐ Yes	Please describe:
Neurological concerns? *For example: seizures, migraines*	☐ No	☐ Yes	Please describe:
Serious infections or sexually transmitted infections (STIs) *For example: hepatitis, herpes*	☐ No	☐ Yes	Please describe:
Chickenpox? *i.e. Did you have in childhood?*	☐ No	☐ Yes	Please describe:
Blood concerns? *For example: Blood clots in your legs or lungs, bleeding disorders*	☐ No	☐ Yes	Please describe:
Stomach problems? *For example: Irritable bowel syndrome, acid reflux*	☐ No	☐ Yes	Please describe:
Bladder or kidney problems?	☐ No	☐ Yes	Please describe:
Thyroid problems or diabetes?	☐ No	☐ Yes	Please describe:
Other concerns: *For example: Back or spine problems*	☐ No	☐ Yes	Please describe:
Mental health concerns? *For example: Anxiety, depression, bipolar disorder, psychosis.*	☐ No	☐ Yes	Please list any medications or hospital admissions:
Substance use concerns? *For example: treatment with suboxone, methadone, etc*?	☐ No	☐ Yes	Please describe:
Immunizations: • *When was your last flu shot?* • *How many doses of a Covid-19 immunization have you had?*			

Lifestyle / Social History

Are you on a special diet? *For example: vegan, vegetarian* *(You can visit tinyurl.com/pregnancyplate for information on diet in pregnancy)*	☐ No	☐ Yes	Please describe:
Do you exercise regularly? *(Did you know: 150 mins of exercise per week can help maintain a healthy weight, help with aches/pains of pregnancy, and help you avoid gestational diabetes and hypertension/preeclampsia?)*	☐ No	☐ Yes	Please describe the exercise you do, and how often:
Do you drink alcohol?	☐ No	☐ Yes	How many drinks per week *before* pregnancy? _____ How many drinks per week *during* pregnancy? _____ When was your last drink? _____ Do you ever drink 4 or more drinks at a time?
Do you smoke cigarettes or use a vape?	☐ No	☐ Yes	How many cigarettes per day before pregnancy? _____ During pregnancy? _____ How often did you vape each day before pregnancy? _____ During pregnancy? _____ Quit day (if applicable): _____
Are you around secondhand smoke?	☐ No	☐ Yes	From who?
Do you smoke marijuana? *Or vaporize, or consume edibles?*	☐ No	☐ Yes	
Do you use any other recreational drugs? (e.g. meth, cocaine, heroin)	☐ No	☐ Yes	Please describe:
Do you have concerns about, or problems with, finances or housing? *For example: Difficulty paying bills or rent, receiving social assistance*	☐ No	☐ Yes	Please describe:
Do you have a stable support system to help you throughout this pregnancy and when caring for your newborn?	☐ No	☐ Yes	Please describe:

Tell us more about the care you want

Please list any concerns for this pregnancy, or general questions, that you would like us to talk about on your first visit.

On behalf of the team at the Burnaby Maternity Clinic,
we welcome you and look forward to caring for your pregnancy!