



# BURNABY MATERNITY CLINIC

## FIRST PRENATAL VISIT QUESTIONNAIRE

Please email the form to [burnabymaternity@fraserhealth.ca](mailto:burnabymaternity@fraserhealth.ca) or bring it to your first appointment.

### About you

Name: \_\_\_\_\_

Date of Birth (DD/MM/YYYY): \_\_\_\_\_ Preferred pronouns: \_\_\_\_\_

Personal Health Number (PHN): \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

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  Yes  No

Occupation: \_\_\_\_\_ Hours of work/day: \_\_\_\_\_

Highest level of education: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Preferred language: \_\_\_\_\_ Do you require a translator at your appointments: \_\_\_\_\_

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Pre-pregnancy weight: \_\_\_\_\_

### About your partner (if applicable)

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Preferred pronouns: \_\_\_\_\_

Occupation: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**About your current pregnancy**

What is important to you for your care during this pregnancy? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is this an IVF (in vitro fertilization) pregnancy?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
Any spotting or bleeding?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	At how many weeks? _____
Any nausea?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Is it getting better, worse, or staying the same? _____
Any infections or fevers?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe: _____ _____
When was the first day of your last menstrual period?			
Is your menstrual cycle regular?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	How long is your cycle? _____ days
Have you had any ultrasounds for this pregnancy?	<input type="checkbox"/> NO	Have you planned one? <input type="checkbox"/> YES, on _____ (date) at _____ (location) <input type="checkbox"/> NO	
	<input type="checkbox"/> 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?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	

**Your pregnancy history**

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

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

Year	How many weeks?	What surgery or medication did you need, if any?

**Previous births:**

Please provide as much detail as you can.

Date (DD/MM/YY):		Country:	
Name of hospital or birthing centre:			
Weeks pregnant:	Hours of labour:	<input type="checkbox"/> C-section <input type="checkbox"/> Vaginal delivery	<input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum
Complications:			
Baby's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Baby's birth weight:	

Date (DD/MM/YY):		Country:	
Name of hospital or birthing centre:			
Weeks pregnant:	Hours of labour:	<input type="checkbox"/> C-section <input type="checkbox"/> Vaginal delivery	<input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum
Complications:			
Baby's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Baby's birth weight:	

Date (DD/MM/YY):		Country:	
Name of hospital or birthing centre:			
Weeks pregnant:	Hours of labour:	<input type="checkbox"/> C-section <input type="checkbox"/> Vaginal delivery	<input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum
Complications:			
Baby's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Baby's birth weight:	

Date (DD/MM/YY):		Country:	
Name of hospital or birthing centre:			
Weeks pregnant:	Hours of labour:	<input type="checkbox"/> C-section <input type="checkbox"/> Vaginal delivery	<input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum
Complications:			
Baby's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Baby's birth weight:	

Were there any unusual circumstances that happened during your previous births?

*For example: fast delivery, heavy bleeding, retained placenta, shoulder dystocia, breech position*


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### **Your medical history**

Do you have any medication allergies?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Drug(s): _____ Your reaction(s): _____
Are you taking any medicines? Please include any prenatal vitamins and over the counter medications.	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please list all medicines and doses here:

**Have you ever had:**

Surgery? <i>For example: Therapeutic abortions, breast augmentation, other plastic surgery, wisdom teeth removal</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	When were the surgeries, what surgeries, and why?
Problems with anesthesia during surgery?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Procedures or concerns involving the uterus, ovaries or cervix? <i>For example: Abnormal pap smears, cone biopsy</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
When was your last pap smear (DD/MM/YY)?			
Heart or lung problems? <i>For example: High blood pressure, asthma</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Back or spine problems?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Serious infections or sexually transmitted infections (STIs) <i>For example: Hepatitis, herpes</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Chickenpox?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Blood concerns? <i>For example: Blood clots in your legs or lungs, bleeding disorders</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Stomach problems? <i>For example: Irritable bowel syndrome, acid reflux</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Bladder or kidney problems?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Thyroid problems or diabetes?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Neurological concerns? <i>For example: Seizures, headaches</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:

Mental health concerns? <i>For example: Anxiety, depression, bipolar disorder, psychosis</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please list any medications or hospital admissions:
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Do you have any other health concerns not listed above? \_\_\_\_\_

**Your family history**

**Do you have a family history of:**

Pregnancy complications? <i>For example: High blood pressure, diabetes</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?  Please describe complications:
Birth defects or genetic conditions?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Heart disease? <i>For example: Heart attacks, bypass surgery, strokes, heart failure</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?
High blood pressure?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?
Diabetes?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?
Mental health concerns? <i>For example: Depression, anxiety</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?
Problematic alcohol use?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?
Drug addiction?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?
Clotting disorders? <i>For example: Blood clots in the legs or lungs</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?
Bleeding disorders?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Which relatives?

**Your lifestyle and social history**

Are you on a special diet? <i>For example: Vegan, vegetarian</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
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Do you exercise regularly?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe the exercise you do, and how often:
Do you drink alcohol?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	How many drinks per week before pregnancy? _____ How many drinks during pregnancy? _____ When was your last drink? _____
Do you smoke cigarettes or use a vape?	<input type="checkbox"/> NO	<input type="checkbox"/> 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?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	From who? _____
Do you smoke marijuana?	<input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES	
Do you use any illegal drugs? (e.g. meth, cocaine, heroin)	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Do you have concerns about, or problems with, finances or housing? <i>For example: Difficulty paying bills or rent, receiving social assistance</i>	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe:
Do you have a stable support system to help you throughout this pregnancy and when caring for your newborn?	<input type="checkbox"/> NO	<input type="checkbox"/> 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***