Lions Gate Maternity Clinic

Contact Information

Family Physician: ____________________

Referred By: ____________________

Date: ____________________

Name (as stated on care card): ____________________

Maiden Name: ____________________

Address: ____________________

City: __________ Postal Code: __________

Cell Phone: __________ Home Phone: __________

Care Card #: ____________________

Date of Birth: ____________________

Ethnic Origin: ____________________

Occupation: ____________________

Employer: ____________________

Partner Information

Name: ____________________

Date of Birth: ____________________

Ethnic Origin: ____________________

Emergency Contact and Phone Number: ____________________

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Medical History Form

Please complete the following questionnaire and bring it with you to your first appointment. We would appreciate it if you would fill it in as accurately as possible to facilitate optimal care. The history of current and past pregnancies and any question you might not understand will be discussed at that first appointment.

Please circle YES or NO and provide specifics when indicated

DO YOU HAVE ANY ALLERGIES?	YES	NO	SPECIFY__________________________________
ARE YOU ON ANY MEDICATIONS?	YES	NO	SPECIFY__________________________________
ARE YOU TAKING VITAMINS?	YES	NO	SPECIFY__________________________________
HAVE YOU EVER SMOKED?	YES	NO	QUIT WHEN______________________________
ETHNIC ORIGIN?			____

DATE OF LAST MENSTRUAL PERIOD? ____

NUMBER/DATES OF PREVIOUS PREGNANCIES (include miscarriages and TAs) __________________________________

____

PAST MEDICAL HISTORY

Date of last PAP Test__________________________________

Serious illnesses in the past?	YES	NO	SPECIFY__________________________________
Heart problems/murmurs?	YES	NO	SPECIFY__________________________________
Respiratory or Lung problems?	YES	NO	SPECIFY__________________________________
High blood pressure?	YES	NO	
Diabetes or Thyroid disease?	YES	NO	SPECIFY__________________________________
Sexually transmitted disease?	YES	NO	SPECIFY__________________________________
Have you had Chicken Pox?	YES	NO	
Kidney or bladder problems?	YES	NO	SPECIFY__________________________________
Stomach or bowel problems?	YES	NO	SPECIFY__________________________________
Blood clots or bleeding problems?	YES	NO	SPECIFY__________________________________
Depression or Anxiety	YES	NO	SPECIFY__________________________________
Seizures or neurological problems?	YES	NO	SPECIFY__________________________________
History of Cancer?	YES	NO	SPECIFY__________________________________
Alcohol or other substance problems?	YES	NO	SPECIFY__________________________________

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PAST SURGICAL HISTORY

Any operations?	YES	NO	SPECIFY________________________________
Anesthetic problems?	YES	NO	SPECIFY________________________________
Blood transfusions?	YES	NO	SPECIFY________________________________

FAMILY HISTORY

Cleft Palate, Down Syndrome, Spina Bifida?	YES	NO	SPECIFY________________________________
Diabetes and gestational diabetes?	YES	NO	SPECIFY________________________________
High blood pressure or strokes?	YES	NO	SPECIFY________________________________
Heart conditions or heart attacks?	YES	NO	SPECIFY________________________________
Depression, anxiety other mental illness?	YES	NO	SPECIFY________________________________
Premature or fast labours?	YES	NO	SPECIFY________________________________
Blood clots or bleeding problems?	YES	NO	SPECIFY________________________________
Alcohol or other substance problems?	YES	NO	SPECIFY________________________________
Genetic defects or inherited diseases?	YES	NO	SPECIFY________________________________
Cancer?	YES	NO	SPECIFY________________________________

Family Doctor? ____

Your Name ____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM

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TWEAK Score

Questionnaire on Alcohol Use During Pregnancy

*To be completed **early** in **all** pregnancies*

When having a baby one of the areas your care provider will talk about is your use of alcohol. The following questions will help with the discussion.

How may drinks does it take to make you feel high?
Number_______

Have close friends or relatives worried or complained about your drinking in the past year?

☐ No ☐ Yes

Do you sometimes have a drink in the morning when you first get up?

☐ No ☐ Yes

Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?

☐ No ☐ Yes

Do you sometimes feel the need to cut down on your drinking?

☐ No ☐ Yes

Talk about your answers to the above questions with your health care provider.

Source: Russell, M (1994). New Assessment tools for risk drinking during pregnancy: T-ACE,TWEAK and others.Alcohol Health and Research World.