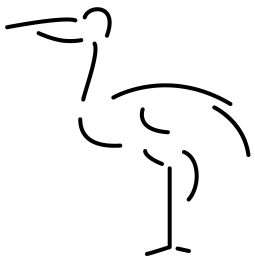

Lions Gate Maternity Clinic

Please complete these forms to the best of your ability, leaving blank any that you're unsure about. We will review all questions with you on your initial meeting.

Date _____

Family Physician _____

Referred By _____

Name (as stated on care card) _____

Maiden Name _____ Preferred Pronouns _____

Street 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 _____

Occupation _____

EMERGENCY CONTACT

Name _____

Phone Number _____

Medical History

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.

Your Name _____

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 Specify _____

Date of last menstrual period? _____

Date of last PAP test? _____

Height _____ Weight (before pregnancy) _____

Previous Pregnancy, Miscarriage, or Abortion Dates

_____

_____

_____

Immunizations

Most recent dates if known.

	Date
Flu	_____
Tdap (boostrix)	_____

Personal Medical History

Past Surgeries?	◯ Yes	◯ No	Specify _____
Anesthetic problems?	◯ Yes	◯ No	Specify _____
Seizures or neurological problems?	◯ Yes	◯ No	Specify _____
Heart problems/Lung problems?	◯ Yes	◯ No	Specify _____
High Blood Pressure?	◯ Yes	◯ No	Specify _____
Stomach or bowel problems?	◯ Yes	◯ No	Specify _____
Uterine/Cervix procedures?	◯ Yes	◯ No	Specify _____
Kidney or bladder problems?	◯ Yes	◯ No	Specify _____
Blood transfusions?	◯ Yes	◯ No	Specify _____
Blood clots or bleeding problems?	◯ Yes	◯ No	Specify _____
Diabetes or Thyroid disease?	◯ Yes	◯ No	Specify _____
Depression, anxiety, other mental illness?	◯ Yes	◯ No	Specify _____
Have you ***had*** Chicken Pox?	◯ Yes	◯ No	Specify _____
Sexually Transmitted Infections?	◯ Yes	◯ No	Specify _____

Family History - Mother

Anesthetic problems?	◯ Yes	◯ No	Specify _____
High blood pressure or strokes?	◯ Yes	◯ No	Specify _____
Blood clots or bleeding problems?	◯ Yes	◯ No	Specify _____
Diabetes and gestational diabetes?	◯ Yes	◯ No	Specify _____
Depression, anxiety, other mental illness?	◯ Yes	◯ No	Specify _____
Alcohol or other substance problems?	◯ Yes	◯ No	Specify _____
Thyroid Disorders?	◯ Yes	◯ No	Specify _____
Other			Specify _____

Family History - Mother & Biological Father / Donor

Cleft Palate, Down Syndrome, Spina Bifda?	◯ Yes	◯ No	Specify _____
Genetic defects or inherited diseases, e.g. Congenital Heart Defect, Cystic Fibrosis, Tay-Sachs, Sickle Cell, Thalassemia, GP6D Deficiency, other	◯ Yes	◯ No	Specify _____

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.