ASPEN MATERNITY
AND WOMEN'S HEALTH CLINIC

Questionnaire

Congratulations on your pregnancy!

We're pleased you have chosen Aspen Maternity Group for your maternity care. To assist us in providing the best care for you, it is very helpful for us to gather basic information about you and your health, as well as some information on this pregnancy and previous pregnancies.

Please fill out this form before your first appointment, and bring your completed questionnaire with you to your first appointment. At your first visit, your doctor will review this health information, go over your questions, and make plans for follow up including a complete physical early in your pregnancy.

Your first name
Preferred name Partner's name

Your age at due date Partner's age
Your Last name Partner's ethnic background
Your occupation Partner's occupation
Your Date of Birth
Language preferred

Your Relationship status: ☐married ☐living with partner ☐single (never married) ☐separated ☐divorced ☐widowed

Your highest level of education completed:
☐less than high school ☐high school diploma ☐trade or other certificate
☐Undergraduate university degree ☐Postgraduate university degree

Do you identify with an Indigenous identity?
☐none ☐First Nations ☐Metis ☐Inuk ☐Status ☐Non-Status ☐Live on Reserve ☐Off Reserve

Your Ethnicity:

☐ Indigenous
☐ European - Western (eg. English, Italian)
☐ European - Eastern (eg. Russian, Polish)
☐ Asian East (eg. Chinese, Japanese, Korean)
☐ Asian South Indian (eg. Pakistan, Sri Lankan)
☐ Asian South East (eg. Malaysian, Filipino)
☐ Middle Eastern - (eg. Iranian, Lebanese)
☐ African
☐ Caribbean
☐ Latin American (eg. Argentinean, Chilean)
☐ Other _____

Do you have any beliefs or practices (eg Jehovah's Witness) that would influence your management in labour and delivery? _____

Before getting pregnant, what contraceptive type did you use? _____
When did you last use contraceptives? _____
Was this pregnancy planned? ☐ Yes ☐ No

Medications:

Please list any medications , including vitamins and supplements which you are currently taking or have taken since becoming pregnant:

☐ preconception folic acid ☐ 1st trimester folic acid

_____

_____

Allergies:

Please list any allergies and the reactions you had to each:

_____

_____

_____

Obstetric history:

Have you been pregnant before? ☐Yes ☐No If so how many times? _____

How many children do you have? _____

We'll be asking you more questions about your previous pregnancies when we see you in person. If there is anything you want to make sure we discuss at the visit regarding a previous pregnancy, please feel free to make some notes in the space below:

_____

_____

_____

When was the **first** day of your **last menstrual period**? _____

Did you have artificial reproductive treatment to get pregnant? ☐Yes ☐No

Method: ☐Ovarian stimulation only ☐ IUI only ☐Ovarian stimulation and IUI

☐IVF ☐ICSI ☐Other

Have you had any bleeding in this pregnancy?	☐Yes ☐No
Are you nauseated?	☐Yes ☐No
Are you vomiting more than once a day?	☐Yes ☐No
Have you had any infections in this pregnancy?	☐Yes ☐No
Have you had any other complications or problems in this pregnancy?	☐Yes ☐No
Have you or your partner traveled recently? If so, where? _____	☐Yes ☐No
When was your last pap smear? _____	
Any history of abnormal paps? (If so, when? _____)	☐Yes ☐No

In your family, does anyone have any of the following problems:

Babies or children with heart disease	☐Yes ☐No
High blood pressure	☐Yes ☐No
Diabetes	☐Yes ☐No
Alcohol or drug abuse	☐Yes ☐No
Blood clot in the legs (DVT) or bleeding /clotting problems	☐Yes ☐No
Have any babies in your family or your partner's family been born with a birth defect or genetic problem, or died when they were a baby?	☐Yes ☐No

Please give details for any of the above issues that run in your family:

_____

_____

_____

Medical history:

Have you ever struggled with your mood after a pregnancy? ☐Yes ☐No

Have you ever had an eating disorder (anorexia or bulimia or overeating)? ☐Yes ☐No

Are there any other problems you have had with your health? ☐Yes ☐No

Please give more details of any of the above problems with your health:

Have you had Hypertension before, or previous hypertension in pregnancy? ☐Yes ☐ No

Have you had any Bowel or bladder problems? ☐Yes ☐ No

Have you had any gyne problems or procedures to the uterus or cervix? ☐Yes ☐ No

Have you had any thromboembolic problems or blood clots ? ☐Yes ☐ No

Have you had Diabetes? ☐type 1 ☐type 2 ☐Gestational Diabetes ☐Yes ☐ No

Have you had any thyroid problems? ☐Yes ☐No

Have you had any mental health conditions? ☐Yes ☐ No

Please specify:

☐anxiety ☐depression ☐ Bipolar ☐Eating disorder ☐Other

Have you had substance use disorder? ☐Yes ☐No

☐on methadone treatment ☐on suboxone treatment

Have you had any infectious diseases like chicken pox, herpes simplex virus? ☐ Yes ☐No

Please specify _____

Have you received immunizations for: ☐Flu shot ☐Tdap ☐Covid-19 ☐ Yes ☐No

Lifestyle history:

Do you have questions about diet in pregnancy? ☐Yes ☐No

Please give more details about your concerns:

What do you normally do for exercise? _____

Do you have good financial support? ☐ Yes ☐ No

Do you have adequate housing and food? ☐ Yes ☐ No

Do you have access to transportation? ☐ Yes ☐ No

Do you feel safe? ☐ Yes ☐ No

Has your partner or anyone been violent to you? ☐Yes ☐No

Are you concerned about the safety of you or your baby or other children at home? ☐Yes ☐No

How many drinks of Alcohol per week have you had in the 3 months before pregnancy? _____

How many drinks per week of Alcohol do you drink now? _____

Do you drink 4 or more drinks at a time? ☐Yes ☐No

How many cigarettes did you smoke per day in the 3 months before pregnancy? _____

How many cigarettes do you smoke per day now during pregnancy? _____

Are you exposed to second hand smoke? ☐ Yes ☐No

Have you quit smoking cigarettes? (if so, quit date: _____) ☐Yes ☐No

Other drugs during pregnancy:
Have you used Cannabis in the 3 months before or during pregnancy? ☐ Yes ☐ No
How many times _____ per ☐day ☐week ☐month
CBD products only ☐ Yes or ☐ No
Primary route ☐smoke ☐vape ☐edible
Have you quit using cannabis products? (if so, quit date _____)
Any other drugs use during pregnancy? ☐ Yes ☐ No
☐Cocaine ☐opioids ☐methamphetamines ☐IV drugs ☐prescription drugs
How often were you using this/these drugs? _____
Are you still using this/these drugs? If so, how often? _____

Is there anything we should know about your home situation that would help us to provide better care for you?

Questions:
Please write down your questions below.
We will cover as many of them as we are able in the first visit, and if more time is needed, we will book another appointment to review the rest of your questions:

1.
2.
3.
4.
5.

Congratulations again on your pregnancy!