# Langley Maternity Clinic

## FIRST PRENATAL VISIT QUESTIONNAIRE

Please answer the following questions as thoroughly as possible as it will help your provider with your maternity care.

**About You**

Name: _____ Age: _____DOB (DD/MM/YYY): _____

Preferred Pronouns: _____ Maiden Name (if different than current name): _____

Marital Status (Married/Single/Widowed/Divorced/Common Law): _____

Personal Health Number (PHN): _____ Primary Care Provider: _____

Preferred Phone Number: _____ Alternate Phone Number: _____

Home address (including city & postal code):

_____

_____

Email: _____

Optional: I consent to the use of email for information affecting my care. YES ☐ NO ☐

Signature: _____ Date: _____

Do you identify as Indigenous: _____

Highest level of education: _____ Ethnicity: _____

Occupation: _____ Hours of work/day: _____

Preferred language: _____ Do you require a translator: _____

**About Your Partner (If applicable)**

Name: _____ Age: _____

Preferred Pronouns: _____ Occupation: _____ Ethnicity: _____

**Your Medical History**

| | NO | YES | If yes: |
|---|---|---|---|
| Do you have any medication allergies? | ☐ | ☐ | Drug(s): _____<br>_____<br>Reaction(s): _____<br>_____ |
| Are you taking any medications? Please include any prenatal vitamins and over the counter medications. | ☐ | ☐ | Please list all medications and doses here: |
| In the event of an emergency would you consent to receive blood transfusion or blood products? | ☐ | ☐ | |

**About Your Current Pregnancy**

| When was the first day of your last menstrual period? | | | |
|---|---|---|---|
| | **NO** ☐ | **YES** ☐ | **If yes:** |
| Have you had any ultrasounds for this pregnancy? | ☐ | ☐ | If yes, when was your last ultrasound?<br><br>On _____ (date), at _____ (location). |

**About Your Pregnancy History**

If this is your first pregnancy, skip the next page.

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

_____
_____
_____
_____
_____
_____
_____

**Previous Births:**

Please provide as much detail as you can. If you have had more than one child, please ask the front desk for additional pages.

| | | |
|---|---|---|
| Date (DD/MM/YY): | | |
| Name of hospital/Place of birth: | | |
| Baby's gender at birth:<br>☐ Male ☐ Female | Baby's birth weight: | Please check all that apply:<br>☐ Baby was breast fed<br>☐ Baby was formula fed |
| Weeks pregnant at delivery: | Hours of labour: | Type of birth:<br>☐ C – Section ☐ Forceps<br>☐ Vacuum ☐ Vaginal delivery |

| | | |
|---|---|---|
| Did you experience any of the following complications: | **NO** ☐ | **YES** ☐ |
| Did you require help starting labour or during labour? | ☐ | ☐ |
| Medications used for pain control? If yes, please list: | ☐ | ☐ |
| Did you need stitches? | ☐ | ☐ |

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

We understand the sensitivity of this section, please take your time to provide as much detail as you can. It will ultimately help your provider ensure receive the best maternity care possible.

| Approximate date | Weeks pregnant at time of loss. | Did you require a procedure? If yes, please describe. | Did you require medication? If yes, please list. |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**About Your Current Pregnancy (continued)**

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

_____
_____
_____
_____
_____

| | NO | YES | If yes: |
|---|---|---|---|
| Is this an IVF (in vitro fertilization) pregnancy? | ☐ | ☐ | Date of embryo transfer (DD/MM/YYY): |
| Any spotting or bleeding? | ☐ | ☐ | At how many weeks: |
| Any nausea? | ☐ | ☐ | Is it the same, worse, or improving? |
| Any travel during pregnancy? (Self or Partner) | ☐ | ☐ | Location and length of travel: |
| Any infections or fevers? | ☐ | ☐ | Please describe: |

**Your Family History**

| | NO | YES | If yes: |
|---|---|---|---|
| Pregnancy complications? *For example: High blood pressure, diabetes* | ☐ | ☐ | Which relatives?<br><br>Please describe complications: |
| Complications with anesthetic? | ☐ | ☐ | Which relatives?<br><br>Please describe complications: |
| Heart disease? *For example: Heart attacks, bypass surgery, strokes, heart failure* | ☐ | ☐ | Which relatives?<br><br>Please describe conditions: |
| High blood pressure? | ☐ | ☐ | Which relatives: |
| Clotting or bleeding disorders? *For example: Blood clots in the legs or lungs* | ☐ | ☐ | Which relatives: |
| Diabetes? | ☐ | ☐ | Which relatives: |
| Mental health concerns? *For example: Depression, anxiety* | ☐ | ☐ | Which relatives: |

| | | | |
|---|---|---|---|
| Problematic alcohol use? | ☐ | ☐ | Which relatives: |
| Drug addiction? | ☐ | ☐ | Which relatives: |
| Birth defects or genetic conditions? | ☐ | ☐ | Which relatives:<br><br>Please describe: |

**Your Medical History (continued)**

**Have you ever had:**

| | NO | YES | If yes: | | |
|---|---|---|---|---|---|
| Surgery? *For example: Therapeutic abortions, breast augmentation, other plastic surgery, wisdom teeth removal* | ☐ | ☐ | Date of surgery: | What surgery: | Reason for surgery: |
| | | | | | |
| Problems with anesthesia during surgery? | ☐ | ☐ | Please describe: | | |
| Neurological concerns? *For example: Seizures, headaches* | ☐ | ☐ | Please describe: | | |
| Back or spine problems? | ☐ | ☐ | Please describe: | | |
| Heart or lung problems? *For example: High blood pressure, asthma* | ☐ | ☐ | Please describe: | | |
| Stomach problems? *For example: Irritable bowel syndrome, acid reflux* | ☐ | ☐ | Please describe: | | |
| Bladder or kidney problems? | ☐ | ☐ | Please describe: | | |
| Procedures or concerns involving the uterus, ovaries, or cervix? For example: Abnormal pap smears, cone biopsy | ☐ | ☐ | Please describe: | | |

| | | | |
|---|---|---|---|
| Blood concerns? *For example: Blood clots in your lungs, bleeding disorders* | ☐ | ☐ | Please describe: |
| Thyroid problems or diabetes? | ☐ | ☐ | Please describe: |
| Mental health concerns? *For example: Anxiety, depression, bipolar disorder, psychosis* | ☐ | ☐ | Please list any medications or hospital admissions: |
| Serious infections or sexually transmitted infections? *For example, Hepatitis, Herpes* | ☐ | ☐ | Please describe: |
| Recent immunizations? | ☐ | ☐ | Immunization and date: |
| OTHER: | Please describe: | | |

**Your Lifestyle and Social History**

| | **NO** | **YES** | **If yes:** |
|---|---|---|---|
| Are you on a special diet? *For example: vegan, vegetarian* | ☐ | ☐ | Please describe: |
| Do you exercise regularly? | ☐ | ☐ | Please describe the exercises you do, and how often: |
| Do you have concerns about or problems with finances, housing, or transportation? *For example: difficulty paying bills, receiving social assistance* | ☐ | ☐ | Please describe: |
| Do you have a stable support system to help you throughout and after this pregnancy? | ☐ | ☐ | Please describe: |
| Have you experienced gender based violence? If yes, please speak with your provider. | | | |
| Do you drink alcohol? | ☐ | ☐ | How many drinks/week before pregnancy? _____<br>How many drinks during pregnancy? _____<br>When was your last drink? _____ |

| | | | |
|---|---|---|---|
| Do you smoke cigarettes or use a vape? | ☐ | ☐ | How many cigarettes/day before pregnancy? _____<br>During pregnancy? _____<br>How often did you vape each day before pregnancy? _____<br>During pregnancy? _____<br>Quit day (if applicable): _____ |
| Are you around second-hand smoke? | ☐ | ☐ | From who and how often? |
| Do you consume marijuana or CBD? | ☐ | ☐ | Please describe: |
| Do you use any other drugs? *For example: meth, cocaine, heroin* | ☐ | ☐ | Please describe: |

**About You (continued)**

Height: _____ Pre-pregnancy weight: _____ Current weight: _____

Date of last pap smear (DD/MM/YYYY): _____

**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.

_____
_____
_____
_____
_____
_____

Langley Division of Family Practice
MATERNITY
NETWORK

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

Perinatal Services BC
An agency of the Provincial Health Services Authority

# 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 of drinks _____ | |
| 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.*