Health Assessment

Your name: _____ Date of birth: _____

Care card: _____ Your age at your due date: _____

Your height: _____ Your pre-pregnant weight: _____

Have you ever had any of the following? Please check all that apply.

□ Diabetes □ High blood pressure □ Autoimmune disorder □ Kidney disease □ Seizures
□ Eating disorder □ Heart disease □ Asthma □ Kidney infection □ Heart murmur
□ Thyroid disease □ Breast reduction □ Abnormal Pap □ Any other chronic health concern
□ Medication allergy □ None of the above

If you checked any of the above, please give more details:

Please list all surgeries you have had:

If this is not your first pregnancy, have you previously experienced any of the following?

□ Preterm labour □ High blood pressure □ Pre-eclampsia □ Heavy bleeding
□ Growth restricted baby □ Stillbirth □ Gestational diabetes
□ Postpartum infection requiring antibiotics □ Any other serious complication
□ None of the above

If you checked any of the above, please give more details:

Have you ever experienced any of the following?

□ Depression □ Postpartum depression □ Anxiety
□ Bipolar □ Addiction □ Alcoholism
□ Interpersonal violence or any kind of abuse □ None of the above

If you checked any of the above, please give more details, including treatment and your current status:

Do any of the following apply to this pregnancy?

□ Twins □ Conceived with IVF □ Conceived with ICSI □ Severe nausea
□ Bleeding □ Infections/fever in pregnancy □ Smoking, substance or alcohol use
□ None of the above

If you checked any of the above, please give more details:

Are there any other health concerns you would like to discuss with us?
