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?

_____