Noakes Maternity
AT RICHMOND HOSPITAL

About you:

What kind of work do you do? _____ How many hours/week? _____

What is the highest level of schooling you have achieved? _____

What is your ethnic background? _____ Do you follow a faith or religion? _____

What was your weight before pregnancy? _____ How tall are you? _____

What was the first day of your last menstrual period? _____ What is your age? _____

About your baby's father and other family supports:

Is the father involved?_____ What is his name? _____ How old is he? _____

What kind of work does he do? _____ What is his ethnic background? _____

Who will be helping you when you go home with your baby? _____

Do you have concerns about being a parent? _____

About your lifestyle: (either fill in the answer or circle Y or N)

Do you exercise regularly? Y or N
If so, what type? _____

Do you smoke tobacco? Y or N

Are you exposed to someone else's smoking? Y or N

Do you use cannabis products? Y or N

Since becoming pregnant, have you had alcohol? Y or N

Do you use any recreational drugs? Y or N

Do you have any dietary restrictions? Y or N

Do you have any pets? Y or N
If yes, which ones? _____

Have you had any recent international travel, or are you planning to travel during the pregnancy?
If so, where? _____

About your medical history:

Do you take any regular medications? Please list: _____

Do you take any supplements or non-prescription meds? Please list: _____

Do you have any allergies to medications? _____If so, what type of reaction?_____

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Have you had any previous surgeries: Please check ☑

Breast surgery ☐ type: _____
Uterine surgery ☐ type: _____
Cervical biopsy ☐ type: _____
Back surgery ☐ type: _____

Gallbladder surgery ☐
Appendectomy ☐
Other: _____
Other: _____

Do you have any of the following medical or psychiatric conditions:

Asthma ☐
Thyroid disease ☐
Diabetes ☐
High blood pressure ☐
Liver disease ☐
Autoimmune disease ☐
Kidney or bladder problems ☐

Bowel disease ☐
Seizures ☐
Depression ☐
Anxiety ☐
Other: _____
Other: _____
Other: _____

Have you or the baby's father had any of these infections:

Cold sores	you ☐	father ☐	HIV	you ☐	father ☐
Genital herpes	you ☐	father ☐	Hepatitis	you ☐	father ☐
Chlamydia	you ☐	father ☐	Chicken Pox	you ☐	father ☐
Gonorrhea	you ☐	father ☐			

About your family's health history:

Are there any genetic or congenital (present at birth) diseases that run in your family or your partner's family: _____

Is there anyone in the immediate family (parents or siblings) who have the following conditions:

Diabetes ☐
Thyroid disorder ☐
Heart disease or defect ☐
Lung disease ☐
Hepatitis ☐

Kidney disease ☐
Other: _____
Other: _____

Pregnancy complications? If so, do you know what type? _____