Noakes Maternity
AT RICHMOND HOSPITAL

Prenatal Intake Questionnaire

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? _____

Would you like a translator for your visits? Yes ☐ No ☐
If so, which language are you most comfortable with? _____

What would you like us to know about you? _____
_____
_____
_____

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? _____

Is your partner in this pregnancy the same person as the baby's father? Yes ☐ No ☐

About your lifestyle:

Do you exercise regularly?

Yes ☐ No ☐

What type of Exercise? _____

Do you smoke tobacco?

Yes ☐ No ☐

Are you exposed to someone else's smoking?

Yes ☐ No ☐

Do you use cannabis products?

Yes ☐ No ☐

Since becoming pregnant, have you had alcohol?

Yes ☐ No ☐

How much did you drink before becoming pregnant? _____

Do you use any recreational drugs?

Yes ☐ No ☐

Do you use e-cigarettes or vape?

Yes ☐ No ☐

Do you have any dietary restrictions?

Yes ☐ No ☐

Do you have any pets?

Yes ☐ No ☐

If yes, which ones? _____

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

Yes ☐ No ☐

If yes, 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?_____

Have you had any previous surgeries:

☐ 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? _____

Please fax or email this form to our clinic once complete.

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Phone: 604-233-3222
Email: ChildHealthCentreRichmondHospital@vch.ca