Noakes Maternity
AT RICHMOND HOSPITAL

Prenatal Intake Questionnaire

About You:

What is your preferred name? _____ Preferred pronouns: _____ Your age:_____

Your relationship status: _____ What kind of work do you do? _____

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

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

Would you like a translator for your visits? No ☐ Yes ☐ preferred language: _____

Do you have a Primary Care Provider (GP/NP)? _____

About your baby's father and other family supports:

Do you have a partner? _____ What is your partner's name? _____ Pronouns:_____

Their Age? _____ Ethnicity?_____ What kind of work do they do? _____

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

Do you have concerns about being a parent? _____

Pregnancy history:

When was the first day of your last menstrual period? _____

Have you ever been pregnant before?_____

Please list the year and month of each pregnancy and describe the outcome (for example miscarriage, abortion, vaginal delivery, Caesarean section, etc.) and any important details:

_____

_____

_____

About your lifestyle:

Do you exercise regularly?

Yes ☐ No ☐

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 ☐

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

Yes ☐ No ☐

If yes, where? _____

Medical History:

Do you take any prescription medications?

Please list:

_____

_____

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

_____

_____

Do you have any severe allergies?

_____

What is the 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 ☐	partner ☐
Genital herpes	you ☐	partner ☐
Chlamydia	you ☐	partner ☐
Gonorrhea	you ☐	partner ☐
HIV	you ☐	partner ☐
Hepatitis	you ☐	partner ☐
Chicken Pox	you ☐	partner ☐

About your family's health history:

List any genetic or congenital (present at birth) diseases that run in yours or the father's families:

_____

Does anyone in your immediate family (parents or siblings) have the following conditions:

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

Other: _____

Other: _____

Any pregnancy complications for your immediate female relatives? _____

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

Fax: 604-233-5620
Phone: 604-233-3222
Email: ChildHealthCentreRichmondHospital@vch.ca