Your name:
Health Care Number:
Your husband's/partner's name:
Date of appointment:

**OBSTETRICAL HISTORY:** First day of the last menstrual period (YYMMDD):____________________
Total number of:
Pregnancies: _______Children: _______Miscarriages: ______Abortions: ______Ectopics: ______

| YYMMDD | Hospital | Gest Age | Hours In Labour | Delivery Type (Normal, Vacuum, Forceps, Cesarean) | Complications | Sex | Weight |
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**Medical History:** (please circle appropriate answer/ if yes please specify):

Asthma No Yes ____________________
Autoimmune (eg. Lupus) No Yes____________________
Bleeding/Clotting Problems No Yes____________________
Heart problems No Yes____________________
High Blood Pressure No Yes____________________
Diabetes No Yes____________________
Thyroid No Yes____________________
GI (bowel) problems No Yes____________________
Epilepsy No Yes____________________
Kidney problems No Yes____________________
Hepatitis/liver disease No Yes____________________
HIV/AIDS No Yes____________________
Chlamydia/Gonorrhea/Herpes/Warts No Yes____________________
Tuberculosis (Tb) No Yes____________________
Chicken Pox or Vaccine No Yes____________________
Psychiatric (Depression/anxiety) No Yes____________________
Assisted conception (Clomid/IVF) No Yes____________________

Anesthetic problems No Yes____________________
Blood transfusions No Yes____________________
Operations No Yes____________________
Other No Yes____________________
Allergies No Yes____________________
Height ____________________

**Life Style History/Social History:** (if yes, please specify how much/how long/etc)

Do you smoke? No Yes__________Quit (YYMMDD)__________
Alcohol use in pregnancy? No Yes____________________
Drug use? No Yes__________ Quit (YYMMDD)__________
Do you work? No Yes (please specify type of work) ____________________

**Family History:** (please specify who in the family is affected)

Diabetes No Yes____________________
Heart problems No Yes____________________
High Blood Pressure No Yes____________________
Malformation/Birth Defects No Yes____________________
Mental Illness/Depression No Yes____________________
Twins/multiple pregnancy No Yes____________________
Husband/partner a blood relative?
(e.g.. First/second cousins) No Yes____________________
Other No Yes____________________

**Medications:** Please list your medications below, including prenatal vitamins: