grow health | Family, Maternity & Pediatric Care

Congratulations on your pregnancy! We're thrilled you have chosen Grow Health for your maternity care. Some we get to know you better, please fill out this form before your first appointment. Your doctor will go over this information with you at your first visit. Welcome!

Your name _____ Age _____ Preferred Pronoun _____

Partners Name_____ Partners Age _____ Partners Pronoun_____

Your ethnic background _____ Partner's ethnic background _____

Your occupation _____ Partner's occupation _____

How did you hear about us? _____

Do you have a family doctor? ☐ Yes, Dr _____ ☐ No, I don't

Medications:

Please list any medications, including vitamins and supplements, which you are currently taking or have taken since becoming pregnant

_____ _____

_____ _____

_____ _____

Allergies:

Please list any allergies and the reaction you had to each

_____ _____

_____ _____

_____ _____

Have you been pregnant before? If so, how many times? _____
How many children do you have? _____

If you plan to breastfeed, are there any issues we should be aware of so we can provide extra supports or resources?_____

Please give details of previous deliveries:

Date - city - Type of birth - hrs in labour - complications of preg or delivery - baby's weight - Sex

1. _____

2. _____

3. _____

4. _____

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

Did you have In Vitro Fertilization (IVF) to get pregnant?	☐ Yes	☐ No
Have you had any bleeding in this pregnancy?	☐ Yes	☐ No
Are you nauseated?	☐ Yes	☐ No
Are you vomiting more than once a day?	☐ Yes	☐ No
Have you had any infections in the pregnancy?	☐ Yes	☐ No
Have you had any other complications or problems in this pregnancy?	☐ Yes	☐ No
Have you had your flu shot?	☐ Yes	☐ No

When was your last pap smear? _____ Any history of abnormal paps? _____

Please give details if you've had any of the problems listed above, or anything else you think we should know about this pregnancy

_____

_____

In your family, does anyone have any of the following problems?

Babies or children with heart disease?	☐ Yes	☐ No
High blood pressure?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Depression, anxiety or mental health challenges?	☐ Yes	☐ No
Alcohol or drug abuse?	☐ Yes	☐ No
Blood clot in the legs (DVT) or bleeding/clotting problem?	☐ Yes	☐ No
Have any babies in your family or your partner's family been born with a birth defect or genetic problem, or died when they were a baby?	☐ Yes	☐ No

Please give details for any of the above issues that run in your family:

_____

_____

_____

Your medical history:

Have you ever had surgery for any reason?	☐ Yes	☐ No
Have you ever had a problem with an anesthetic for surgery?	☐ Yes	☐ No
Have you ever had any procedures on your uterus or your cervix?	☐ Yes	☐ No
Do you have any heart or lung problems?	☐ Yes	☐ No
Have you ever had herpes or other sexual infections?	☐ Yes	☐ No
If yes, which one(s)? _____		
Have you had chicken pox?	☐ Yes	☐ No
Have you ever had a blood clot in your leg or a bleeding/clotting disorder?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No
Do you have any problems with your stomach or bowels?	☐ Yes	☐ No
Do you have any kidney or bladder problems?	☐ Yes	☐ No
Do you have diabetes or thyroid problems?	☐ Yes	☐ No
Have you ever had a seizure or other neurological problem?	☐ Yes	☐ No
Have you ever had depression, anxiety or manic-depression?	☐ Yes	☐ No
Have you ever struggled with your mood after a pregnancy?	☐ Yes	☐ No
Have you ever had an eating disorder (anorexia, bulimia, overeating)?	☐ Yes	☐ No
Are there any other problems you've had with your health?	☐ Yes	☐ No

Please give more details if you've had any of the above problems with your health:

_____

_____

_____

_____

Over the past two weeks, how often have you been bothered by the following? (place an X)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Feeling nervous, anxious or on edge				
4. Not being able to stop or control worrying				

Before you knew you were pregnant, did you smoke cigarettes? ☐ Yes ☐ No

If yes, how many cigs/day? _____

How much do you smoke now? _____

Before you knew you were pregnant, did you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks would you have in a week? _____

How many drinks/week now? _____

Before you knew you were pregnant, were you using cannabis? ☐ Yes ☐ No

If yes, how much were you using before pregnancy? _____

How much do you use now? _____

Were you using any other substances prior to becoming pregnant? ☐ Yes ☐ No

Which substances were you using? _____

Does your **partner** smoke or use any substances? ☐ Yes ☐ No

If yes, please give details _____

Who will be helping you after the baby is born? _____

Is there anything we should know about your home situation, your relationship with your partner, your relationship with your family, issues at work that you are finding challenging or any other issues that we can help you with? Difficult situations can sometimes be challenging to talk about but we hope you'll let us know if there's anything we can help with. We are often able to provide resources and support for a variety of challenging situations.

☐ Yes, there are issues I would like to discuss with you ☐ No, I don't have any concerns

Are there any other concerns you have about your health or your pregnancy? Anything else we can help you with or that you think we should know about you?

_____

_____

_____

_____

_____

_____

Congratulations again on your pregnancy and welcome to Grow Health. We are very excited to be with you on this exciting journey!