Cold Lake OB Clinic

Please fill out this form to the best of your ability. Please be assured that all information will be kept confidential and will only be used to complete your Alberta Prenatal form.

Full Name: (Please use name on your Alberta Health Card)
Marital Status (married, single, common-law):
Maiden Name:
Date of Birth (mm/dd/yyyy):
Daytime Phone Number:

Emergency Contact Name:
Emergency Contact Phone Number:

Your Occupation:
Your Ethnicity (ie: Phillipine, First Nation, etc.):
Language Spoken at home:
Your Family Physician:

Baby's Fathers Ethnicity (ie: Phillipine, First Nation, etc.):
Baby's Father's Name:
Phone Number:
Occupation:

Current Pregnancy

First date of last menstrual period:	Are you sure of your dates?

Any Previous prenatal care or investigations (labs, ultrasounds) for this pregnancy?

Pre-pregnancy weight:

Pregnancy History

Please list all previous pregnancies including abortions and miscarriages.

Date of birth or loss	Place of delivery	Gestational age in Weeks	Time in labour	Delivery type	Complication with pregnancy, delivery or after	Sex	Birth weight	Name	Healthy
Ie: Jan 12, 2000	Bonnyville	40	16 hours	vaginal	Gestational diabetes, high blood pressure	M	6lbs 10oz	Owen	Yes

Family History

Has anyone in **your family** or the **baby's father's family** had any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Mental Illness/Depression	☐	☐
Heart Disease	☐	☐	Twins/Triplets	☐	☐
High Blood Pressure	☐	☐	Other Illness: _____	☐	☐
Malformations / Birth Defects	☐	☐		☐	☐

Medical History

Have **you** had any of the following:

	Yes	No		Yes	No
Asthma	☐	☐	Sexually Transmitted Infections	☐	☐

Autoimmune Disorders	☐	☐	Tuberculosis	☐	☐
Bleeding/Clotting disorder	☐	☐	Chicken pox/Varicella	☐	☐
Heart Problems	☐	☐	Mental Illness/Depression	☐	☐
High Blood Pressure	☐	☐	Assisted Conception	☐	☐
Diabetes (Type 1: __ Type 2: __ Gestational: __)	☐	☐	Type:	☐	☐
Thyroid Problems	☐	☐	Anesthetic Problems	☐	☐
Stomach/Bowel problems	☐	☐	Blood Transfusions	☐	☐
Epilepsy	☐	☐	Operations	☐	☐
Renal/Urinary tract	☐	☐		☐	☐
Hepatitis/Liver disease	☐	☐		☐	☐
HIV/AIDS	☐	☐	Other Illness: _____	☐	☐

Yes No

Allergies ☐ ☐

If yes, specify allergy and reaction:

Medications

Are you taking any medications or vitamins:

Medication or Vitamin	Dose	When did you start it?
Prenatal Vitamin		
Folic Acid		
Others:		

Do you have any environmental or occupational exposure to toxins (second hand smoke, pets, daycare worker, etc.):

Do you have any social or cultural beliefs that could affect your care (ie: religious beliefs, single parent, low income, no social or family support, etc.):

Substance Use

Do you Use	Yes/No	When did you last use or Quit Day	Max Amount Used

Tobacco			
Marijuana			
Street Drugs			
Alcohol			

Would you like to meet with a dietitian?
Yes / No
Would you like a referral to the Healthy Babies program that offers support for prenatal vitamins, classes and healthy food?
Yes / No
Would you like to attend an early prenatal class?
Yes / No