Your Date of Birth (yyyy/ mm/dd)_____/_____/_____ **Your Initials** _____

Maternal Information

Pre-pregnancy weight _____☐lbs ☐kg (Check) Height_____☐ft ☐cm (Check)

Please select your birth mother's primary ethnicity (up to 2). If more than 2, please select "mixed" and specify below.**:**

☐ Caucasian (European) ☐ African ☐ First Nations
☐ East Asian ☐ South Asian ☐ Other/Multi-ethnicity
If other/multi, please list:_____

Please select your birth father's primary ethnicity (up to 2). If more than 2, please select "mixed" and specify below **:**

☐ Caucasian (European) ☐ African ☐ First Nations
☐ East Asian ☐ South Asian ☐ Other/Multi-ethnicity
If other/multi, please list: _____

NOTE: East Asian = Chinese/Korean/Japanese/Filipino/Vietnamese etc
South Asian = Indian/Pakistani etc

Please check your highest level of education completed:

☐ High school diploma
☐ Undergraduate degree or equivalent diploma/certificate
☐ Graduate degree or equivalent degree
☐ Other degree or diploma/certificate. Please list: _____

Please list your occupation: _____

Please check your average house hold income:

☐ Less than $50 000 ☐ Greater than $50 000

Previous pregnancies:

# of pregnancies (including current) _____
# of term (>/=37 w) births _____
# of pre-term (</36 w+6d) births _____
# of terminations _____
# of spontaneous miscarriages _____
# of living children _____
# of twin or triplet pregnancies _____

Please provide the following for each child born prior to this pregnancy (add more pages if >2 children):

Child	Year of birth	Gestational age at delivery	Type of delivery	gender	Complications at delivery
1					
2					

Have you had an abnormal Maternal Serum Screen in a previous pregnancy? ☐ NO ☐ YES

If yes, did it indicate a risk for:
☐ Down syndrome (trisomy 21)
☐ Trisomy 18
☐ Open Spina Bifida

When NOT pregnant, do you suffer from:

	NO	YES
Headaches/Migraines?	☐	☐
Kidney disease?	☐	☐
High blood pressure?	☐	☐
Heart attack or stroke?	☐	☐
Type 1 or Type 2 Diabetes?	☐	☐

Does your mother, father, or siblings (brothers or sisters) suffer from:

	NO	YES	If yes who?
Headaches/Migraines?	☐	☐	_____
Kidney disease?	☐	☐	_____
High blood pressure?	☐	☐	_____
Heart attack or stroke?	☐	☐	_____
Diabetes?	☐	☐	_____

Has your mother and/or sisters had more than two spontaneous miscarriages? NO☐ YES ☐

Current Pregnancy Information:

Date of your last menstrual period (LMP) (YYYY/MM/DD)? _____/_____/_____

Date of your estimated due date (EDD) (YYYY/MM/DD)? _____/_____/_____

Did you take vitamins during pregnancy? ☐ NO ☐ YES

If yes, please list the brand/type for the following and which trimester (T) you started:

Ex. Multi-vitamin Centrum ultra for women

☐Prenatal	Brand_____	Start date: ☐ 1st T ☐2nd T ☐3rd T
☐Multi-vitamin	Brand_____	Start date: ☐ 1st T ☐2nd T ☐3rd T
☐Folic Acid	Brand_____	Start date: ☐ 1st T ☐2nd T ☐3rd T
☐Calcium	Brand_____	Start date: ☐ 1st T ☐2nd T ☐3rd T
☐Iron	Brand_____	Start date: ☐ 1st T ☐2nd T ☐3rd T
☐Other	Brand_____	Start date: ☐ 1st T ☐2nd T ☐3rd T

Did you take any vitamins in the 3 months before pregnancy? ☐ NO ☐ YES

If yes, are they the same as above? ☐ NO ☐ YES

If no, please list _____

Did you take medications during pregnancy? ☐ NO ☐ YES

If yes, please check what type and when you used it: T = trimester

☐ Aspirin (Acetylsalicylic Acid)		# of doses _____	Date: ☐ 1st T ☐2nd T ☐3rd T
☐ Tylenol (Acetominophen)		# of doses _____	Date: ☐ 1st T ☐2nd T ☐3rd T
☐ Advil (Ibuprofen)		# of doses _____	Date: ☐ 1st T ☐2nd T ☐3rd T
☐ Diclectin			
☐ Antiseizure	Brand _____	# of Doses_____	Date: ☐ 1st T ☐2nd T ☐3rdT
☐ Highblood pressure	Brand_____	# of Doses_____	Date: ☐ 1st T ☐2nd T ☐3rdT
☐ Antidepressants	Brand _____	# of Doses_____	Date: ☐ 1st T ☐2nd T ☐3rdT
☐ Prescription	Brand _____	# of Doses_____	Date: ☐ 1st T ☐2nd T ☐3rdT
☐ Other	Brand _____	# of Doses_____	Date: ☐ 1st T ☐2nd T ☐3rdT

Please check any of the following complications you experienced in this pregnancy

- ☐ Bleeding
- ☐ Fever
- ☐ Rash
- ☐ Infection Type: _____
- ☐ Vomiting
- ☐ Headaches/migraines
- ☐ High blood pressure
- ☐ Abdominal pain
- ☐ Gestational Diabetes

Please check any of the following exposures you experienced in this pregnancy:

- ☐ 1st hand Cigarette smoke more than 3 times a week
- ☐ 2nd hand Cigarette smoke more than 3 times a week
- ☐ alcohol **prior** to 12 weeks gestational age (1st trimester)
- ☐ alcohol **after** 12 weeks gestational age (1st trimester)