Southern Health Santé Sud

MATERNAL DATABASE

Date ___________
Height ___________
Weight ___________
BMI ___________

OBSTETRICAL SUMMARY

G ________ **P** ________ **EDC (U/S or LNMP)** _____/______/______ **Rh**_________ **Last WinRho** _______________________________
Circle one DD MM YYYY

GBS_____ **Hgb** ________ **Date** _______ **Allergies (Type and Reaction)** ____

PREVIOUS PREGNANCIES

Year	Place of Birth	Gestation Weeks	Duration of Labour	Type of Delivery	Anaesthesia	Sex	Birth Weight	Complications/Comments ☐ See Prenatal Record

SIGNIFICANT MEDICAL HISTORY-See Prenatal Record ☐

	Yes	No	Comments
Cardiovascular	☐	☐	_______________
Varicose Veins	☐	☐	_______________
Hemorrhoids	☐	☐	_______________
Hypertension	☐	☐	_______________
Diabetes	☐	☐	_______________
Genitourinary	☐	☐	_______________
Infections	☐	☐	_______________
Varicella	☐	☐	_______________
Tuberculosis/Exposure	☐	☐	_______________
Reproductive	☐	☐	_______________
Epilepsy	☐	☐	_______________
Thyroid Dysfunction	☐	☐	_______________
Asthma	☐	☐	_______________
Bleeding Disorders	☐	☐	_______________
Thrombosis/Phlebitis	☐	☐	_______________
Migraines	☐	☐	_______________
Edema	☐	☐	_______________
Vision/Hearing Issues	☐	☐	_______________
Skin	☐	☐	_______________
Gastrointestinal	☐	☐	_______________
__________________	☐	☐	_______________
__________________	☐	☐	_______________

Hep B: Positive ☐ Negative ☐
Rubella: Susceptible ☐ Immune ☐

MEDICATIONS IN THIS PREGNANCY

(including Non-Prescription)

***See Medication Reconciliation Form**

LIFESTYLE

	Yes	No	
Adequate prenatal care	☐	☐	_______________
Communication Barriers	☐	☐	_______________
Language Spoken			_______________________
			Type/Amount/Frequency
Caffeinated Beverages	☐	☐	_______________
Cigarettes	☐	☐	_______________
Alcohol	☐	☐	_______________
Recreational (street) Drugs	☐	☐	_______________

Type/Time Last Used: _______________________
Nutritional Concerns/Issues: _______________________

OTHER INFORMATION

Is there anything you and your support person would like to share with us? (i.e. Prenatal classes, Expectations, Fears, Concerns)

____
____
____
____

Are you planning to Breast Feed? Yes ☐ **No** ☐

Previous Experience ________________________________
____

COPY TO INFANT CHART

Previous Surgery/Anesthetic/Blood Transfusion:

____

____

Other Medical Concerns:

____

____

PSYCHOSOCIAL INFORMATION

PLEASE TELL US ABOUT YOU AND YOUR FAMILY

Are you & your partner/family happy about this pregnancy?	**Y** ☐	**N** ☐
Do you have a stable relationship with your partner	**Y** ☐	**N** ☐
Do you think your partner has an alcohol or drug dependence?	**Y** ☐	**N** ☐
Have you experienced recent stressful life events?	**Y** ☐	**N** ☐
Will you have support at home after you have your baby?	**Y** ☐	**N** ☐
Have you experienced in the past, or are you currently experiencing any form of physical, sexual, or psychological abuse?	**Y** ☐	**N** ☐
Do you have personal/family history of depression, anxiety, or other mental health issue?	**Y** ☐	**N** ☐
Do you have any concerns about parenting this child?	**Y** ☐	**N** ☐
Do you have a contact with Child & Family Services? **Name of Worker:** ______________________________	**Y** ☐	**N** ☐
Are any of your children not in your care?	**Y** ☐	**N** ☐

PLEASE TELL US MORE

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Social Work consult? **Y** ☐ **N** ☐

VISIT HISTORY

Completed/Updated by:

Signature _____________ **Date** ________ **Gestation (Date/U/S)** ______ **Visit Reason** ____________________________

Signature _____________ **Date** ________ **Gestation (Date/U/S)** ______ **Visit Reason** ____________________________

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