Pioneer Health Pre-Pregnancy Questionnaire

(please complete this before your appointment and give to your doctor)

Name: ____________________

Date of birth: ____________________ Age in years: ____________________

Country of Birth: ____________________

Are you Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Ethnicity: ____________________

OBSTETRIC HISTORY:

1. Have you had a previous pregnancy? ☐ Yes ☐ No (if no please go to question 4.)

2. Please provide us with details of your previous life pregnancies.

2.1 Date of birth of first child ____________________

Any pregnancy or complications? ____________________

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Any complications at birth? ____________________

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Gestation at baby's birth? ____________________

Type of birth: ☐ vaginal ☐ assisted (vacuum cup/forceps)
☐ elective caesarean section ☐ emergency caesarean section

2.2 Date of birth of second child ____________________

Any pregnancy or complications? ____________________

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Any complications at birth? ____________________

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Gestation at baby's birth? ____________________

Type of birth: ☐ vaginal ☐ assisted (vacuum cup/forceps)
☐ elective caesarean section ☐ emergency caesarean section

OBSTETRIC HISTORY (CONT):

2.3 Date of birth of third child ______________________

Any pregnancy or complications? ______________________

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Any complications at birth? ______________________

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Gestation at baby's birth? ______________________

Type of birth:
- ☐ vaginal
- ☐ assisted (vacuum cup/forceps)
- ☐ elective caesarean section
- ☐ emergency caesarean section

2.4 Date of birth of fourth child ______________________

Any pregnancy or complications? ______________________

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Any complications at birth? ______________________

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Gestation at baby's birth? ______________________

Type of birth:
- ☐ vaginal
- ☐ assisted (vacuum cup/forceps)
- ☐ elective caesarean section
- ☐ emergency caesarean section

2.5 Date of birth of fifth child ______________________

Any pregnancy or complications? ______________________

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Any complications at birth? ______________________

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Gestation at baby's birth? ______________________

Type of birth:
- ☐ vaginal
- ☐ assisted (vacuum cup/forceps)
- ☐ elective caesarean section
- ☐ emergency caesarean section

OBSTETRIC HISTORY (CONT):

3. Please provide us with details of any pregnancy loss.

3.1 Date(s) and gestation of any still birth? ______________________________

____

3.2 Date(s) of any miscarriage? ______________________________

____

3.3 Date(s) of any termination(s) (abortion)? ______________________________

____

GYNAECOLOGICAL HISTORY:

4. Date of last menstrual period (first day of bleed): ______________________________

4.1 Are your cycles regular? ☐ Yes ☐ No

4.2 What is the usual length of your menstrual cycle in days? ______________________________

4.3 Are your periods heavy? ☐ Yes ☐ No

4.4 Are your periods painful? ☐ Yes ☐ No

4.5 When did your periods start? ______________________________

5. Do you have a history of endometriosis? ☐ Yes ☐ No

6. Do you use contraception, and if so what type? ☐ Yes ☐ No

____

7. When was your last pap smear? ______________________________

7.1 Have you had abnormal pap smears in the past? ☐ Yes ☐ No

8. Have you had any past gynaecological surgery?
(surgery on your womb, cervix, vagina or ovaries) ☐ Yes ☐ No

9. Do you have any history of pelvic disorder? ☐ Yes ☐ No

MEDICAL HISTORY:

10. Do you have any history of the following:

- ☐ diabetes
- ☐ thyroid disorder
- ☐ autoimmune conditions (e.g. lupus)
- ☐ heart disease
- ☐ high blood pressure
- ☐ blood disorders or clots
- ☐ cancer
- ☐ gut or liver conditions
- ☐ kidney disorder or urinary tract infection
- ☐ infectious diseases (e.g HIV, hepatitis, syphilis)
- ☐ neurological conditions or epilepsy
- ☐ musculoskeletal problems or fractures
- ☐ respiratory conditions including asthma
- ☐ metabolic disorders such as phenylketonurea

PSYCHIATRIC HISTORY:

11. Have you any history of the following:

- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia or psychosis
- ☐ Eating Disorder
- ☐ Personality Disorder

FAMILY HISTORY OF BIRTH DEFECTS:

12. Do you or your partner have a family history of the following:

- ☐ genetic abnormality (such as cystic fibrosis)
- ☐ bleeding disorder
- ☐ nervous system malformation
- ☐ heart defects
- ☐ intellectual disabilities or learning disabilities

13. Are you of Asian or Mediterranean ethnic origin? ☐ Yes ☐ No

14. Are you of Jewish or French Canadian origin? ☐ Yes ☐ No

15. Are you of African or Mediterranean origin? ☐ Yes ☐ No

TRAVEL HISTORY:

Have you travelled overseas since 2015? ☐ Yes ☐ No

If so where have you travelled?____

____

OCCUPATIONAL HISTORY:

16. Do you work in child care? ☐ Yes ☐ No

17. Do you work with industrial chemicals? ☐ Yes ☐ No

VACCINATION HISTORY:

18. Have you had your complete set of childhood vaccinations? ☐ Yes ☐ No

19. Have you had chickenpox? ☐ Yes ☐ No

DENTAL HISTORY:

20. Do you brush and floss your teeth daily? ☐ Yes ☐ No

21. Do you have regular dental check ups? ☐ Yes ☐ No

When did you last see a dentist? ____________________________________

SEXUAL HISTORY:

22. Are you in a monogamous relationship? ☐ Yes ☐ No
23. Could you be at risk of a sexually transmitted disease? ☐ Yes ☐ No
24. Do you have any sexual dysfunction? ☐ Yes ☐ No

MEDICATIONS:

25. Do you take any prescribed medications? ☐ Yes ☐ No

    If so please list them. ____________________

26. Do you take any over the counter medications or supplements? ☐ Yes ☐ No

    If so please list them. ____________________

ALLERGIES:

27. Do you have any allergies to medications? ☐ Yes ☐ No

    If so please list them. ____________________

SMOKING:

28. Do you smoke? ☐ Yes ☐ No

    If so, when did you start and how many cigarettes per day do you smoke? ____________________

    ____

ALCOHOL:

29. Do you take alcohol? ☐ Yes ☐ No

    If so, what do you drink, how much and how often? ____________________

    ____

RECREATIONAL DRUGS:

30. Do you take recreational drugs? (e.g. cannabis, amphetamines) ☐ Yes ☐ No

    If so what type and how often. ____________________