CHATHAM-KENT
Health Alliance

Obstetrical Pre-admission Questionnaire

Please complete all pages and print clearly.

General Patient Information:

Last Name (as written on Health card): _____

First Name (as written on Health card): _____

I prefer to be called _____

Date of Birth: _____/_____/_____ Age: _____ Baby's Due Date: _____/_____/_____
M D Y M D Y

Address: _____ Apt/Unit # _____

City: _____ Province: _____ Postal Code: _____

Home phone: _____ Work: _____ Other: _____

Language: _____ Do you require an Interpreter? ☐ No ☐ Yes

If you require an interpreter, will someone be accompanying you to the hospital? ☐ No ☐ Yes

Are there any cultural/religious practices you would like to share with your health care team to assist us in caring for you? _____

_____

_____

Is there any other information that you would like us to know?

_____

_____

_____

My Family Doctor's Name is: _____

Delivering Doctor/Midwife's Name: _____

My baby's Doctor will be: _____

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Please complete all pages and print clearly.

Next of Kin:

Name: Last: _____ First: _____

Relation to me: _____

Their address is: ☐ same as mine, or:

_____ City: _____

Home phone: _____ Work: _____ Other: _____

Alternate Contact if we are unable to contact you: ☐ same as Next of Kin

Name: Last: _____ First: _____

Relation to me: _____

Their address is: ☐ same as mine, or:

_____ City: _____

Home phone: _____ Work: _____ Other: _____

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Pre-Admission Questionnaire

Medical History:

1. Do you have any allergies? ☐ No ☐ Yes If yes, please list and describe your reaction:

_____

_____

2. Do you take any medications (incl. herbal and nutritional supplements, please)? If yes, please list:

_____

_____

3. My height: _____ Pre-pregnancy weight: _____ Current weight: _____
4. Number of previous pregnancies: _____ Number of pregnancy/children losses: _____
5. Number of children: _____ Age of children at home: _____
6. Have you arranged care for your child(ren) while you are in the hospital? ☐ No ☐ Yes

If no, please explain: _____

7. Past pregnancy history (any problems?): _____

_____

_____

8. Current pregnancy history (any problems with this pregnancy?): _____

_____

9. Is this birth a surrogacy or adoption matter? ☐ No ☐ Yes If yes, explain _____

_____

10. Have you ever had a blood transfusion before? ☐ No ☐ Yes If yes, why?

_____

_____

11. Many women experience periods of anxiety and mood swings following the birth of a baby. Are there any of the following factors that might contribute to post partum mood or anxiety issues for you?

☐ Family history of depression (who?): _____

☐ Personal history of depression ☐ Recent personal or family stress

Comment: _____

_____

12. Have you had previous surgeries (including a previous Cesarean Section)? ☐ No ☐ Yes

What was it? _____

_____

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Expectations for Your Birth

1. Are you planning a vaginal delivery? ☐ No ☐ Yes ☐ VBAC (If no please go to #)
2. Who will be your support person/people (max 2)? _____
3. What is their relationship to you? _____
4. What are your plans for comfort measures?:

☐ Breathing techniques	☐ Walking	☐ Massage
☐ Birthing Ball	☐ Music	☐ Position changes
☐ Nitronox ("laughing gas")	☐ Shower/Whirlpool tub	☐ Heat/Cold packs
☐ Sterile Water Injections	☐ Injection of pain medication	☐ PCA
☐ Epidural	☐ other: _____	

5. If you are having a Cesarean Section, when is it booked for? _____/_____/_____
   M D Y
6. How was your last birth experience? Please explain: _____
   _____
7. Did you Breastfeed your other child(ren)? ☐ No ☐ Yes If yes, how long? _____
8. How do you plan to feed this baby? _____
9. Do you have a birth plan? ☐ No ☐ Yes If yes, please provide us with a copy to assist us in meeting your expectations.

Please discuss your birth plan with your delivering physician or midwife.

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Social History

1. Which of the following have you attended:

   ☐ Prenatal classes ☐ Breastfeeding classes ☐ Hospital Tour

2. Do you have any help or support once your baby arrives? Who? _____

3. Do you feel you eat a healthy diet? _____

4. Are you active? What kind of activities do you do? _____

5. Do you have health care insurance (i.e. OHIP)? _____

6. Do you receive assistance from community agencies (i.e. Social Services, Children's Aid Society, Public Health)? ☐ No ☐ Yes If yes, explain: _____

7. Do you feel safe in your current living situation? ☐ No ☐ Yes

8. Do you plan on returning to your current living situation? ☐ No ☐ Yes

9. Have you ever been hit, slapped, kicked or otherwise physically hurt by someone? ☐ No ☐ Yes

10. Did you drink alcohol prior to pregnancy? ☐ No ☐ Yes If yes, how much per week: _____

11. Did you drink alcohol during this pregnancy? ☐ No ☐ Yes If yes, how much per week: _____

12. Did you smoke prior to this pregnancy? ☐ No ☐ Yes If yes, when did you stop? _____

13. Did you smoke during this pregnancy? ☐ No ☐ Yes If yes, how many per day? _____

14. Does anyone else in the house smoke? ☐ No ☐ Yes If yes, how many per day? _____

15. Do you or your partner use street drugs? ☐ No ☐ Yes If yes, explain: _____

    _____

16. Would you like to speak to a hospital social worker after your delivery? ☐ No ☐ Yes

17. Do you have any concerns about this pregnancy or birth? _____

    _____

18. If you would like to speak with a nurse about this questionnaire, please contact Women & Children's Unit at -352-6401 ext 6707.