



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: _____

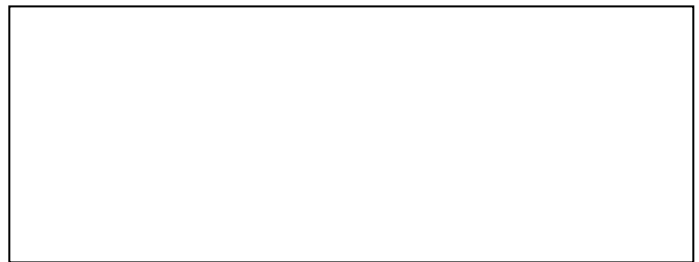
Relation to me: _____

Their address is: same as mine, or:

_____ City: _____

Home phone: _____ Work: _____ Other: _____





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?): _____

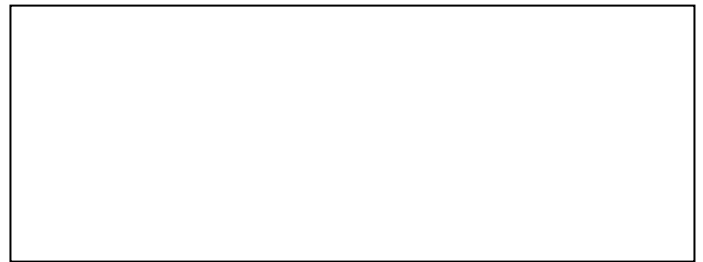
Personal history of depression

Recent personal or family stress

Comment: _____

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

What was it? _____



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?:

<input type="checkbox"/> Breathing techniques	<input type="checkbox"/> Walking	<input type="checkbox"/> Massage
<input type="checkbox"/> Birthing Ball	<input type="checkbox"/> Music	<input type="checkbox"/> Position changes
<input type="checkbox"/> Nitronox ("laughing gas")	<input type="checkbox"/> Shower/Whirlpool tub	<input type="checkbox"/> Heat/Cold packs
<input type="checkbox"/> Sterile Water Injections	<input type="checkbox"/> Injection of pain medication	<input type="checkbox"/> PCA
<input type="checkbox"/> Epidural	<input type="checkbox"/> 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.



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.