Sol Midwifery Prenatal Questionnaire

This optional questionnaire is designed to help us get to know you better, and to understand your feelings about your pregnancy so far. You are welcome to write answers to the questions, or just think about them yourself and consider how it might impact you during your pregnancy. We are happy to discuss anything with you at your next visit, or not discuss it at all if you prefer. This will become a confidential component of your medical record.

We make an effort to ensure confidentiality. However, because we may be working closely with your partner, family and or friends, it would be helpful if you would tell us if there is any information you want us to be particularly careful to disclose.

Name:

Midwife Team:

Current Pregnancy

1. Do you have a Family Doctor or Nurse Practitioner? If so, what is their name and practice?

2. Do you have any drug or food allergies? YES NO
If yes, what are you allergic to and what is your reaction?

3. What medications or supplements do you take?

4. Basic Demographic Information:
Your last name at birth:
Your Ethnic background:
Preferred language:
Your Occupation:
Typical hours of work per day:

If you have a partner:
Partner's name:
Their age:
Their ethnic background:
Their occupation:

5. Was this pregnancy planned or unplanned? If so, how long were you trying to conceive?

6. How long are your menstrual cycles (i.e. from the first day of your period, to the next time your period arrives; average is 28 days)?

7. Were you using contraception before getting pregnant?
If so, what method?
When did you stop using contraception (if applicable)?

8. Was this pregnancy conceived using:
IVF? If so, what method was used and when was implantation?
Donor sperm?
Ovarian Stimulation?

9. Have you had any bleeding, infections, or fevers so far in the pregnancy?

10. Are you experiencing nausea, and if so what have you tried to help you with it?

Pregnancy History

Please list any past pregnancies that were miscarried or terminated:

Year	Length of pregnancy (in weeks)	Miscarriage or termination?	Did you require medication or surgery to complete the process?	Any complications? (e.g. bleeding, infection, difficulty recovering, depression / anxiety)

Please list any past pregnancies that were carried past 20 weeks:

Year	Place of birth	Hrs in active labour	Length of pregnancy (in weeks)	Type of birth (Vaginal, Forceps, Vacuum, Cesarean)	Any complications? (e.g. pregnancy issues, major interventions in labour, bleeding, infection, difficulty recovering, etc.)	Sex and name of baby	Birth weight	Did you breastfeed? For how long?

Your Medical History

Please complete as much of this portion of the questionnaire as you can. If you are unsure what we are asking or prefer not to write down your answer, put a star next to the question and we can talk about it in person.

Question	Examples	Y	N	Comments
Have you had any surgeries?	Wisdom Tooth Extraction, Dilation and Curettage.			If yes, please include the date, anesthetic and if any complications arose.
Have you had any bad reactions to general or local anesthesia	Myasthenia Gravis, Anaphylaxis.			
Do you have a history of neurological conditions?	Multiple Sclerosis, migraines, seizures, concussions/ brain injury.			
Do you have a history of respiratory conditions?	Asthma requiring an inhaler, COPD.			
Do you have a history of heart problems?	Heart murmur, valve prolapse.			
Have you ever had high blood pressure?				
Have you had problems with your bowels?	Celiac, Crohn's, IBS, frequent constipation			
Have you had problems with your bladder or kidneys?	Frequent UTIs, kidney stones			
Have you had any procedures on your uterus or cervix?	Surgery, biopsy or LEEP due to an abnormal pap smear, or fertility treatment investigations			

Have you had any sexually transmitted infections? If you have a partner, do they have genital herpes?				If yes, please specify which one and when they were treated?
Have you had any issues with clotting your blood?	Hemophilia or being unable to stop bleeding, having a clot form in your legs or lungs, stroke			
Do you have a history of anemia?	Iron deficiency, thalassemia, sickle cell			
Have you had problems with your hormonal systems?	Thyroid problems, diabetes, polycystic ovary syndrome			
Do you have any current or past mental health issues?	Anxiety, depression, postpartum depression, PTSD, bipolar			If so, are you taking medication or going to therapy for it?
Have you ever had the chicken pox or varicella vaccine?				
Do you wear contacts or glasses?				
Any problems with your spine and pelvis?	Scoliosis, major accidents or broken bones, limitations on movement			
Do you have varicose veins?	Swollen, painful veins in the legs, groin or vulva			
Do you have any moles that you are concerned about?				
Have you had a PAP or HPV swab done before?				If so, when was your most recent test and what was the result?
How tall are you?				
What did you weigh pre-pregnancy?				

Alcohol Use:
On average, how many drinks per week would you have pre-pregnancy?
Would you consume >4 drinks in one sitting pre-pregnancy? Y/N
Have you had any alcohol this pregnancy?

Cigarette Use:
Are you currently smoking cigarettes during this pregnancy? Y/N
Are you exposed to second-hand smoke regularly?
If yes to above, please answer the following:

- How many cigarettes per day did you consume before this pregnancy?
- And currently?
- Are you planning to reduce your use during pregnancy?
- Would you like us to connect you to resources that discuss quitting?

Marijuana Use:
Are you using THC or CBD products during this pregnancy? Y/N
If yes to above, please answer the following:

- What is the primary route of your use? (Smoke, vape, edible)
- Are you planning to reduce your use during your pregnancy?

Are you exposed to second-hand marijuana smoke regularly?

Are you currently using any of the following (check off those that apply):

- ☐ Cocaine
- ☐ Methamphetamines
- ☐ Opioids
- ☐ Non-prescribed prescription drugs
- ☐ Heroin
- ☐ Fentanyl
- Other:

Has substance use been problematic / concerning for you in the past or at present?

Your Family History

These questions refer to your immediate family **(parents, siblings, grandparents).** You can include other family members if you think they have a condition that could affect your health in pregnancy or your newborn's health.

Question	Examples	Y	N	Comments
Anyone with Anesthetic Complications?	Myasthenia Gravis			
Anyone with high blood pressure?				If so, please indicate if they take medications for it.
Anyone with diabetes?				If so, please indicate if it was from childhood or later in adulthood (Type I or II if known).
Anyone with major mental health issues?	Depression, schizophrenia, bipolar			
Anyone with alcohol or drug use that has been problematic?				
Anyone with blood clotting issues?	Hemophilia or being unable to stop bleeding, having blood clots in the legs or lungs, strokes			
Any inherited diseases in your family, or in your partner's?	Muscular dystrophy, Cystic fibrosis, Tay sach's, or other unexpected conditions in family babies at birth			
Any significant health conditions in your partner or sperm donor that you think could affect your baby's health?	For example, having had a heart defect at birth			

Your Social History

What are your dietary preferences/restrictions?

What do you do to move your body (yoga, swimming, walking, weight training)?

Are you currently able to pay your monthly food and housing expenses? If you face financial barriers, please ask to discuss community resources that can offer support.

Do you have extended health benefits to cover medications, physiotherapy, acupuncture, therapy, etc.?

Do you have access to a vehicle or will you be taking the taxi/bus to appointments?

1 in 5 pregnant people experience intimate partner abuse during their perinatal period. Do you have any concerns about your safety (emotional, physical or sexual) in your current relationship?

Have you experienced past emotional, physical or sexual abuse / assault that you want your midwives to know about? *These questions, though difficult and personal, are asked because we want to provide you with care that is sensitive and tailored to your needs. Some people need additional support, resources and referrals related to their past experiences. If you choose not to answer this question, you are welcome to discuss these issues at any later time with your midwives.*

Who are your main support people (e.g. people who can help you after you've had your baby, if you are undergoing stress, if you need help with childcare, etc.)?

Do you have any cultural, philosophical beliefs, or religions that you follow?

In an emergency situation, would you consent to being given blood products?

Do you have a physical, cognitive, or invisible disability? If so, how can our team make care more accessible to you?

Thank you for taking the time to complete this questionnaire. Please save a copy and email it to admin@solmidwifery.ca, or print it out and bring it with you to your next appointment.