

INITIAL MATERNAL/FETAL ASSESSMENT

Pre-Birth Service

| Name | | P.B.S. appointment date <small>year / month / day</small> | | F | Stimuli, Causes or Factors | | | |
|---|-----|---|---|---|----------------------------|----------------|------------------|-----------------------------|
| Doctor/midwife | | Family doctor | | | | | | |
| G | T | P | A | L | Due date | | | |
| Antenatal Records 1 & 2 <input type="checkbox"/> Not available <input type="checkbox"/> Reviewed by nurse <input type="checkbox"/> No prenatal care | | | | | | | | |
| Allergies | | | | | | | | |
| Explain reaction | | | | | | | | |
| Blood group | | Rh immune <input type="checkbox"/> Neg <input type="checkbox"/> Pos | | Rubella <input type="checkbox"/> Immune <input type="checkbox"/> Not immune | | | | |
| HBAg <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown | | | HIV <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not tested | | | | | |
| <input type="checkbox"/> Herpes <input type="checkbox"/> Genital warts <input type="checkbox"/> Chlamydia <input type="checkbox"/> PID <input type="checkbox"/> Other | | | <input type="checkbox"/> Other Hepatitis type | | | | | |
| The information that you give helps your health care team to personalize your care during your pregnancy, delivery and postpartum experience. The content of this form will only be shared with your health care providers. | | | | | | | | |
| 1. How old are you? | | | | | | | | |
| 2. What is your country of birth? | | | | | | | | |
| 3. How long have you lived in Canada? | | | | | | | | |
| 4. Do you have any religious/cultural concerns practices related to your pregnancy and/or childbirth that could help us with your care? <input type="checkbox"/> No <input type="checkbox"/> Yes—explain | | | | | | | | |
| 5. Language spoken | | What languages can you read? | | | | | | |
| 6. Last grade completed | | Name of support person/interpreter in labour | | | | | | |
| 7. Do you wear <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts | | 8. Do you have <input type="checkbox"/> Hearing difficulties | | 9. Other (eg. disabilities) | | | | |
| 10. Weight pre-pregnancy | | Present weight | Wt. gain | Height | | | | |
| 11. What medications / over-the-counter medications, vitamins, herbal remedies do you take? | | | | | | | | |
| 12. Have you had any problems with this pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes—explain | | | | | | | | |
| 13. Did you see a doctor/midwife in your first three months of this pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | | |
| 14. Have you had any problems with your other pregnancies or deliveries (physical, emotional)? <input type="checkbox"/> No <input type="checkbox"/> Yes—explain | | | | | | | | |
| 15. HISTORY OF PREVIOUS PREGNANCIES | | | | | | | | |
| No. | Yr. | Sex | Gest. Age (weeks) | Birth Wt. (kg) (lbs) | Length of Labour | Place of Birth | Type of Delivery | Comments, eg. Complications |
| | | | | | | | | |
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| 16. Do you have any medical problems (past/present), eg. heart disease, diabetes, epilepsy, high blood pressure, malignant hyperthermia, other? | | | | | | | | |

