

**Leslie K. Po, MD MSc FRCSC**

Obstetrician & Gynecologist

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**Please take a few minutes to answer the following questions prior to your appointment with Dr. Po. You will have the chance to clarify any of the questions once you meet with the doctor. This will hopefully make your appointment more efficient and focused.**

**Name:**

**Date of Birth**:

**Pregnancy History**

1. Including your current pregnancy, how many pregnancies have you had?
2. How many children do you have at home?
3. If you have had previous pregnancies, please complete the list below. Include any miscarriages, abortions or ectopic pregnancies.

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| --- | --- | --- | --- | --- |
| Year | Place of Birth | Gestation (weeks) | Type of Delivery | Issues in Pregnancy |
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|  |  |  |  |  |

1. Did you need to see a fertility specialist to conceive this pregnancy? Yes No

**If yes**, did you have IVF or IUI? Yes No

1. For this pregnancy, did you do a first trimester ultrasound to confirm the due date? Yes No
2. In this pregnancy, have you had any of the following:
   1. Bleeding? Yes No

**If Yes**, when did you have bleeding and how much?

* 1. Nausea/vomiting? Yes No

**If Yes**, how much often?

**Medical History**

1. Do you have any medical conditions or previous admissions to the hospital? Please list.

1. Have you had any surgeries in the past? Please list.

1. Are you taking any regular medications, vitamins or supplements? Please list.

1. Do you have any allergies to medications or latex? Please list.

1. Do you have any special dietary restrictions? Yes No

**If Yes,** please provide details:

1. Did anyone in your family have diabetes, thyroid disease, clots in the legs or lungs, strokes, anesthesia issues or depression *during pregnancy*? Yes No

**If Yes,** please provide details:

1. Have you ever had chicken pox or the chicken pox vaccine? Yes No
2. Have you ever had a sexually transmitted infection? Yes No
3. Have you ever had a genital herpes? Yes No

**If Yes**, when was the last time you had an episode?

1. When was your last pap?       Was the result: Normal or Abnormal

Have you ever had an abnormal pap? Yes No

1. Have you ever had or still have mood problems, anxiety or depression? Yes No

**If Yes**, do you see a doctor or therapist?

1. Do you currently smoke? Yes No
2. Do you currently use cannabis in any form? Yes No
3. Do you use recreational drugs? Yes No
4. When was your last alcoholic drink?

**Patient and Partner Information**

1. Is there a partner involved in this pregnancy? Yes No

**If Yes**, what is his/her/their name?

1. If you work, what are your occupations?

You:

Partner:

1. What are your ethnic backgrounds?

You:

Partner:

1. Has there been any family history or children born with genetic or developmental issues in either families? Yes No

**If Yes**, please describe:

1. Who lives at home with you?

Do you feel safe living at home? Yes No

***Thank you for completing this form!***