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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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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!***