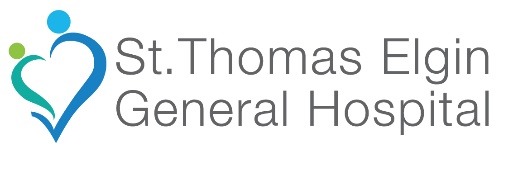
** Pre-Admit Assessment**

**PERSONAL HISTORY**

1. First and Last Name: Click or tap here to enter text.
2. Support Person: Click or tap here to enter text. Relationship: Click or tap here to enter text.
3. Language Spoken: Click or tap here to enter text. Do you require an Interpreter?  No  Yes
4. Date of Birth: Click or tap to enter a date.
5. Health Card Number: Click or tap here to enter text. No OHIP
6. Address: Click or tap here to enter text.
7. Phone Number: Click or tap here to enter text.
8. Emergency Contact Name: Click or tap here to enter text.   
   Emergency Contact Phone Number: Click or tap here to enter text.
9. Family Doctor: Click or tap here to enter text. OB/Midwife: Click or tap here to enter text.

**MEDICAL HISTORY**

1. Due Date: Click or tap to enter a date.
2. Height: Click or tap here to enter text. Pre- Pregnant weight: Click or tap here to enter text. Current Weight: Click or tap here to enter text.
3. Allergies?  No  Yes (If yes, please list and describe the reaction):

|  |  |  |
| --- | --- | --- |
| **Allergy** | | **Reaction** |
| 1. | Click or tap here to enter text. | Click or tap here to enter text. |
| 2. | Click or tap here to enter text. | Click or tap here to enter text. |
| 3. | Click or tap here to enter text. | Click or tap here to enter text. |
| 4. | Click or tap here to enter text. | Click or tap here to enter text. |

1. Medications (including vitamins, herbs & supplements)  No  Yes (If yes, please list):

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medications** | | **Dose** | **Time(s) of the day taken** |
| 1. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 2. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 3. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 4. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

1. List any current or previous medical conditions: Click or tap here to enter text.
2. Have you had any surgeries?  No  Yes

If yes, please list and include year: Click or tap here to enter text.

1. Have you ever had a sexually transmitted infection (STI)?  No  Yes

If yes, please list and include year: Click or tap here to enter text.

1. Have you ever had a blood transfusion?  No  Yes   
   If yes, why? Click or tap here to enter text.
2. Do you, or have you ever suffered from  Anxiety  Depression  Postpartum Depression

If yes, please describe: Click or tap here to enter text.

1. Have you experienced a recent personal or family stress that could contribute to post-partum mood or anxiety issues for you?  No  Yes

If yes, please describe: Click or tap here to enter text.

**OBSTETRICAL HISTORY**

1. Any problems/complications with this pregnancy?  No  Yes   
   If yes, please describe: Click or tap here to enter text.
2. Did you use any fertility medications, IUI or IVF to become pregnant:  No  Yes

If yes, please describe: Click or tap here to enter text.

1. Any problems with previous pregnancies/births):  No  Yes

If yes, please describe: Click or tap here to enter text.

1. Is this birth a surrogacy or adoption?  No  Yes  
   If yes, please describe: Click or tap here to enter text.

**SOCIAL HISTORY:**

1. Have you attended:  Prenatal classes  Breastfeeding class  Hospital tour
2. Are you on a specific diet?  No  Yes   
   If yes, explain: Click or tap here to enter text.
3. Did you drink alcohol during this pregnancy?  No  Yes   
   If yes, how much: Click or tap here to enter text.
4. Do you smoke?  No  Yes   
   If yes, how many per day? Click or tap here to enter text.
5. Does anyone in your home smoke?  No  Yes
6. Do you or your partner use street drugs?  No  Yes

If yes, please describe: Click or tap here to enter text.

1. Would you like to speak to a hospital social worker after your delivery?  No  Yes
2. Are you involved with Family & Children’s services?  No  Yes

If yes, Case Worker’s Name: Click or tap here to enter text.

1. Do you feel that you have adequate support to help once you are home?  No  Yes
2. Have you ever experienced abuse (emotional, physical, sexual, psychological)  No  Yes  
   If yes, please explain: Click or tap here to enter text.

**BIRTH PLAN:**

1. What are your plans for delivery? Choose an item.
2. Who will be your support person(s) during labour: Click or tap here to enter text.
3. Who will be present for the birth of your baby: Click or tap here to enter text.
4. What are your plans for comfort measures in labour:

Breathing Techniques  Bath/Shower  Hot/Cold Compresses  Birthing Ball  Massage

Walking  Nitronox (laughing gas)  Music  Wear my own clothes  IM narcotic   
 Epidural  Sterile water injections (for back labour)  Other: Click or tap here to enter text.

1. Are there any customs or traditions you want to perform that we should know about?   
   Click or tap here to enter text.
2. We will help you find different, comfortable positions during the pushing stage of labour.   
   Which of the following would you like to try?

Side lying  Squatting  Sitting  Hands and Knees  Use of a mirror   
 Other Click or tap here to enter text.

1. After the baby is born, I would like:  Skin to skin  Baby wrapped in blanket
2. I plan to: Choose an item.
3. Previous breastfeeding experience?  No  Yes   
   If yes, for how long Click or tap here to enter text.
4. If the baby is a boy, I would like to arrange for a circumcision (Fees apply):  No  Yes
5. I consent to my baby receiving Vitamin K after birth:  No  Yes
6. I would like my baby’s first bath:  In hospital by nurse  At home  
    In hospital by: Click or tap here to enter text.
7. I/We want to be present for all tests and blood work the baby may need:  No  Yes

**If you would like to speak with a nurse in more detail about this form, please contact the Women & Children’s unit: 519-631-2030, Extension 2196**

Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Antenatal records 1 & 2, Obstetrician’s History & Pre-Obstetrical Pre-Admissions Assessment Reviewed by Admitting Nurse:**

Nurse’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_