NOVA SCOTIA PRENATAL RECORD COMPANION QUESTIONNAIRE

Thank you for assisting with understanding your personal health history as part of your overall perinatal care. The following questions are from the Nova Scotia Prenatal Record. Please answer them as accurately as possible. Leave any responses blank if you are uncomfortable answering the question, do not know the answer, or want to ask why the question is important. Your care provider will review the questionnaire with you at one of your upcoming prenatal appointments. The information you provide will be entered by your care provider into your Prenatal Record. Your prenatal record is a communication tool used by your care providers to help achieve the healthiest outcomes for you, your baby, and your family.

DEMOGRAPHICS

Last Name: _____ First Name: _____ Gender: _____ Pronoun: _____

Address: _____ City/Town: _____ Province: _____ Postal Code: _____

Contact Phone: _____ Leave a message: ☐Yes ☐No

Alternate Phone: _____ Leave a message: ☐Yes ☐No

Health Card Number: _____ Date of Birth: _____

Your age at estimated date of delivery: _____ (years)

Highest level of education completed: _____

Employed: ☐Yes ☐No If yes, what is your occupation: _____

Do you have any religious, cultural beliefs and/or practices that may impact your pregnancy, birth, or newborn care?
☐Yes ☐No If yes, please provide details.

What language(s) are you most comfortable using?
☐English ☐French ☐Mi'kmaq ☐Arabic ☐Other_____

Do you require an interpreter? ☐Yes ☐No
What language should the interpreter be fluent in? _____

Do you identify as an Indigenous or Aboriginal person? ☐Yes ☐No If yes, please specify all that apply.

☐First Nations ☐Metis ☐Inuk (Inuit) ☐Other_____

PARTNER/SUPPORT PERSON

Relationship Status: _____ Partner Involved: ☐Yes ☐No ☐Not Applicable

Partner's Name: _____ Partner's Gender: _____ Partner's Pronoun: _____

Partner's Age: _____ Partner Employed: ☐Yes ☐No Partner's Occupation: _____

Do you have a support person instead of (or in addition to) your partner? ☐Yes ☐No
If yes, please provide the name of your support person: _____

PRENATAL AND NEWBORN CARE PROVIDERS

Who is your primary care provider in the community (e.g. family doctor, nurse practitioner)?
_____

☐ I do not have a community primary care provider.

Who will be your baby's primary care provider (e.g. family doctor, nurse practitioner) in the community once your baby is discharged from hospital?
_____

☐ I do not have a community care provider for my baby once they are discharged from hospital.

PREGNANCY DATING

Have you had any ultrasounds in this pregnancy?

☐Yes ☐No

If yes, please fill out details below:

Date of Ultrasound (YYYY/MON/DD)	Where Ultrasound was Done	Gestational Age at Ultrasound (if known)

What was the first day of your last normal menstrual period? _____
(YYYY/MON/DD)

- **What was the average length of your cycle?** _____days
  (From the first day of bleeding one month to the first day of bleeding in the following month.)

- **Was your cycle regular?** ☐Yes ☐No
- **Are you certain about the date above?** ☐Yes ☐No
- **Was this a planned pregnancy?** ☐Yes ☐No

Was your pregnancy conceived with the help of Assisted Reproductive Technologies? (e.g. fertility medication, in vitro fertilization, IVF, intrauterine insemination, etc.)

☐Yes ☐No

- If yes, what type of Assisted Reproductive Technology was used? _____
- What was the due date given to you by the clinic where you had this done? (YYYY-MM-DD) _____
- If applicable, do you know the date of your Embryo Transfer? _____

Is your pregnancy a twin, or triplet pregnancy?

☐Yes ☐No

- If yes, do you know how many placentas and sacs are present? _____

OBSTETRICAL HISTORY

Please list details from all prior pregnancies, including any miscarriages, ectopic pregnancies, etc.

Date (YYYY-MM-DD)	**Place of Birth**	**Gestational Age** (WEEKS)	**Type of Birth**	**Complications/Problems**	**Birth Weight**	**Sex**	**Current Health**	**Nursing Duration**

HEALTH HISTORY

Do you have any allergies to medications?

☐**Yes** ☐**No**

If yes, please list the medication and the type of allergic reaction (e.g. hives, difficulty breathing, etc.).

_____

Do you have an allergy to latex?

☐**Yes** ☐**No**

HEALTH HISTORY (continued)

Have you had any prior surgeries?

☐Yes ☐No

If yes, what were the surgeries, what year were they done, and were there any complications or problems?

Surgery	Year Performed (YYYY)	Complications/Problems

What medications (prescription, over the counter, vitamins, herbal, etc.) were you taking prior to pregnancy? (Include name, dosage, how often you took it each day, and the reason for taking the medication.)

Medication	Dosage and Frequency	Reason for Taking

What current medications (prescription, over the counter, vitamins, herbal, etc.) are you taking now? (Include name, dosage, how often you take it each day, and the reason for taking the medication.)

Medication	Dosage and Frequency	Reason for Taking

HEALTH HISTORY (continued)

Have you had any problems with anesthesia, including local anesthetic, regional (spinal/epidural), or general anesthetic? (Examples include difficulty inserting the breathing tube, severe nausea and vomiting, spinal headache, etc.)

☐**Yes** ☐**No**

If yes, please describe the problem(s).

Do you have any history of spinal surgery, such as Harrington rods, spinal fusion, or laminectomy?

☐**Yes** ☐**No**

If yes, please describe below.

Do you have any problems with lower back pain and/or sciatica?

☐**Yes** ☐**No**

If yes, please describe below.

Do you have a lower back tattoo?

☐**Yes** ☐**No**

Have you had prior blood transfusions?

☐**Yes** ☐**No**

If yes, why did you need the transfusion? And did you have any reactions to the blood transfusion?

If you ever needed a blood transfusion for life saving reasons, would this be acceptable to you?

☐**Yes** ☐**No**

If not, please explain why.

Do you have any previous or current problems with your lungs, such as asthma, chronic obstructive pulmonary disease, etc.?

☐**Yes** ☐**No**

If yes, please describe these problems.

Do you have any heart conditions or concerns such as congenital heart disease, irregular heartbeat, or heart rhythm, enlarged heart, etc.?

☐**Yes** ☐**No**

If yes, please describe these problems?

Do you have a current or history of high blood pressure?

☐**Yes** ☐**No**

If yes, do you take (or did you have to take) medications? Please provide the name, dose, and how often you take (or took) these medication(s).

Have you had high blood pressure in a prior pregnancy?

☐**Yes** ☐**No** ☐**Not Applicable**

If yes, please provide more details about how many weeks you were pregnant when your blood pressure started to increase, any medications you had to take, and how the increased blood pressure impacted your prior pregnancy.

Do you have any neurological issues, such as multiple sclerosis, epilepsy, migraine headaches, etc.?

☐**Yes** ☐**No**

If yes, please provide more details.

Have you ever had any blood problems such as iron deficiency, anemia, low platelets, thalassemia, etc.?

☐**Yes** ☐**No**

If yes, please provide more details.

Have you ever had a blood clot in your legs and/or in your lungs?

☐**Yes** ☐**No**

If yes, provide more detail about when this occurred and how it was treated.

Have you had prior genital herpes simplex virus (HSV)?

☐**Yes** ☐**No**

If yes, when was your last outbreak? If you get recurrent infections, about how often to they occur?

Have you ever been tested for HIV?

☐**Yes** ☐**No**

If yes, when were you tested and why? What were the results from the testing?

_____

Have you ever been tested for Hepatitis B?

☐**Yes** ☐**No**

If yes, when were you tested and why? What were the results from the testing?

_____

Have you ever been tested for Hepatitis C?

☐**Yes** ☐**No**

If yes, when were you tested and why? What were the results from the testing?

_____

Have you ever had any sexually transmitted infections, such as Chlamydia, Gonorrhea, Human Papillomavirus, or Syphilis?

☐**Yes** ☐**No**

If yes, please provide details of the infection(s) and approximately when you had the infection(s)?

Have you ever had any problems with your neck, lower back, joints, or limbs?

☐**Yes** ☐**No**

If yes, please provide more details.

Have you ever been diagnosed with any rheumatoid or autoimmune disorders such as Systemic Lupus Erythematosus (SLE), Rheumatoid Arthritis (RA), or antiphospholipid syndrome, etc.?

☐**Yes** ☐**No**

If yes, please provide more details.

Have you ever had any other gynecological problems, such as abnormal pap smear(s), LEEP and/or cone biopsy, fibroids, endometriosis, etc.?

☐**Yes** ☐**No**

If yes, please provide details about these problems and any treatment or surgery that you required.

Have you had prior breast surgery, such as breast biopsies, breast reduction, or breast augmentation?

☐**Yes** ☐**No**

If yes, please provide more details.

Have you ever had any bowel or liver problems, such as Crohn's Disease, irritable bowel syndrome, constipation, diarrhea, or liver inflammation?

☐**Yes** ☐**No**

If yes, please provide more details.

Have you ever had any kidney or bladder problems, such as frequent bladder infections, kidney infections, or kidney stones?

☐**Yes** ☐**No**

If yes, please provide more details.

Have you ever had an underactive or overactive thyroid?

☐**Yes** ☐**No**

If yes, please describe and list any treatment you have had and any medications you have taken (or currently take) for these conditions.

Do you have Diabetes?

☐**Yes** ☐**No**

If yes, please provide details about when it was diagnosed and how you manage your diabetes (e.g. diet and exercise, oral medication, insulin, or a combination of these).

Have you ever had Gestational Diabetes in a prior pregnancy?

☐**Yes** ☐**No** ☐**Not Applicable**

If yes, please provide details about your approximate gestational age (in weeks or months) when it was diagnosed. Please also describe how it was managed (e.g. diet and exercise, metformin, insulin, or a combination of these).

MENTAL HEALTH

Do you (or have you had) any of the following mental health issues or concerns? Please check all of those that apply. Please provide any further details you feel may be relevant.

☐ Anxiety _____

☐ Depression _____

☐ Prior Postpartum Depression _____

☐ Bipolar disorder_____

☐ Eating disorder_____

☐ Schizophrenia_____

☐ Other_____

Do you have any other mental health or physical health restrictions that currently affect your regular daily activities?

☐**Yes** ☐**No**

If yes, please provide more details.

FAMILY HISTORY

Have any of your immediate family members (father, mother, siblings) had any of the following? Please provide any further details you feel may be relevant.

☐ Anesthesia complications_____

☐ Diabetes _____

☐ High Blood Pressure_____

☐ Heart disease_____

☐ Blood clots or bleeding problems_____

☐ Mental Health (family history of psychiatric disorders, such as depression, anxiety, bipolar disorder, etc.)

_____

☐ Substance use disorder_____

_____

☐ Unknown_____

☐ None of the above

Have any of your immediate or extended family members had genetic or hereditary anomalies (e.g. Tay-Sachs, Sickle Cell, Congenital Heart Defects, Cystic Fibrosis, Muscular Dystrophy, Neimann Pick C, Alstrom, etc.)?

CURRENT PREGNANCY

Have you had any challenges with nausea and/or vomiting in the pregnancy?

☐**Yes** ☐**No**

If yes, is the nausea and vomiting becoming so severe that you need some help managing it?

_____

Have you had any recent illness (in the pregnancy or in the three months prior to pregnancy) that involved a rash and/or fever?

☐**Yes** ☐**No**

If yes, please provide more details.

_____

Have you had any bleeding in the pregnancy?

☐**Yes** ☐**No**

If yes, is your blood type Rh negative and did you receive Rh immune globulin or WinRho?

_____

Have you and/or your partner travelled during this pregnancy? Are you and/or your partner planning to travel during this pregnancy?

☐**Yes** ☐**No**

If yes, please provide more details about where your are planning to travel and when you plan to travel.

Were you taking folic acid prior to conceiving?

☐**Yes** ☐**No**

If yes, what was the dose and about how many months were you on it prior to becoming pregnant?

_____

Are you taking prenatal vitamins?

☐**Yes** ☐**No**

If no, and if you do not have severe nausea and vomiting, it is ideal to take one prenatal vitamin tablet daily. Most large grocery stores and/or pharmacies have designated prenatal vitamin shelves. Be careful to keep these in childproof containers and well away from toddlers to prevent accidental ingestion.

Are you taking any calcium supplementation?

☐**Yes** ☐**No**

If no, please check your prenatal vitamin ingredients and write the dose of calcium in them below?

_____

If you have a diet with low calcium intake, then calcium supplementation of at least 1 gram per day is recommended to decrease the risk of preeclampsia. Dietary sources of calcium include milk, milk alternatives (i.e. yogurt, cheese, fortified plant-based beverages), dark green vegetables such as broccoli, kale, spinach, and canned salmon or sardines.

Are you taking Vitamin D supplementation?

☐**Yes** ☐**No**

If no, please check your prenatal vitamin ingredients and write the dose of Vitamin D in them below?

_____

Vitamin D deficiency is common in pregnancy. A daily allowance of 600 international units (15 mcg) of Vitamin D is recommended for pregnancy and lactating persons. Additional Vitamin D may be required for those who have limited sunlight exposure or live in the northern latitudes, have darker skin tones, choose to cover themselves for cultural or other reasons, have diets low in Vitamin D, or are Indigenous.

What are your plans for infant feeding?

☐Nursing (Breast/Chest Feeding)

☐Non-nursing (Formula Feeding)

☐Undecided

Comments/Questions: _____

HEALTHY PREGNANCY WEIGHT GAIN

What was your height and weight just prior to becoming pregnant?

Height _____

Weight _____

LIFESTYLE/RISK FACTORS

Do you ever have difficulty making ends meet or paying your bills, at the end of the month?

☐**Yes** ☐**No**

Comments:

Do you have any concerns about being able to access healthcare during your pregnancy and/or birth (e.g. challenges with transportation, childcare, no partner or family close by, etc.)?

☐**Yes** ☐**No**

If yes, please provide details.

Do you have someone you can depend on to help you if a problem comes up?

☐**Yes** ☐**No**

Comments:

How does your partner and/or family feel about your pregnancy?

Who will be helping with the baby following birth?

Please give a brief description of where you work and your usual hours of work. For example, is your work weekdays and/or weekends, daytime, or after hours shift work? Does your work consist of desk work, light duties, or heavy lifting?

Have you seen a dentist within the last 6-12 months?

☐**Yes** ☐**No**

Comments:

Do you have any dietary concerns or dietary restrictions that may affect your pregnancy, such as lactose intolerance, gluten sensitivity, veganism, etc.

☐**Yes** ☐**No**

Comments:

Do you have any other food or environmental allergies?

☐**Yes** ☐**No**

If yes, please list these and the type of allergic reaction you have (e.g. hives, difficulty breathing, etc.).

In the past 12 months, were there times when the food for you and your family just did not last and there was no money to buy more?

☐**Yes** ☐**No**

Comments:

SUBSTANCE USE

Did you use tobacco in the past six months?

☐**Yes** ☐**No**

If yes, how much did you smoke/vape per day? _____

If no, what date did you quit using tobacco? _____

Are you currently using tobacco?

☐**Yes** ☐**No**

If yes, how much are you smoking/vaping per day? (Please also note if this is ceremonial tobacco use.)

_____

Are you currently using nicotine replacement therapy?

☐**Yes** ☐**No**

If yes, what amount and how often? _____

Are you currently vaping (e.g. e-cigarettes, vape pens, Juul)?

☐**Yes** ☐**No**

If yes, what are you vaping and how many times per day? _____

Have you used cannabis in the past six months?

☐**Yes** ☐**No**

If yes, what did you use (e.g. smoking, vaping, edibles, etc.) and about how much did you use per day?

_____

Are you currently using cannabis?

☐**Yes** ☐**No**

If yes, please provide details:

Number of times per day or week: _____

Method (e.g. smoking, vaping, edibles, other): _____

Amount & Strength (if known): _____

Have you drunk alcohol in the past six months?

☐**Yes** ☐**No**

If yes, what did you usually drink and how many drinks per week?

_____

Approximately what day was your last drink? _____

(YYYY/MON/DD)

Do you currently drink alcohol?

☐**Yes** ☐**No**

If yes, please answer the following five questions.

What do you drink and how many drinks per day? _____

Do you ever drink four or more drinks at a time?

☐**Yes** ☐**No**

How many drinks does it take to make you feel high? _____

Have people ever annoyed you by criticizing your drinking?

☐**Yes** ☐**No**

Have you ever felt you ought to cut down on your drinking?

☐**Yes** ☐**No**

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

☐**Yes** ☐**No**

Are you using any of the following substances in pregnancy? Check all of those below that apply and please specify how often you use them and how you take them (e.g. smoke, inhale, intravenous, etc.).

☐ Cocaine _____

☐ Methamphetamines _____

☐ Opioids _____

☐ Other _____

☐ Not Applicable

Do you have a history of substance use disorder?

☐**Yes** ☐**No**

If yes, are you on opioid agonist therapy? Please provide your medication name, dose, and frequency.

ETHNICITY AND GENETIC RISK ASSESSMENT

Some health conditions that impact pregnancy can be more common in certain ethnic groups. Do you or the baby's father belong to any of the following ethnic groups? Please check all that apply.

☐ Acadian _____

☐ Black (African, African Canadian, Afro-Caribbean) _____

☐ East Asian (Chinese, Japanese, Korean, Taiwanese) _____

☐ Indigenous (First Nations, Inuk/Inuit, Metis) _____

☐ Latin American (Hispanic, Other) _____

☐ Middle Eastern (Arab, Persian, Afghan, Egyptian, Iranian, Kurdish, Lebanese, Turkish) _____

☐ Southeast Asian (Cambodian, Filipino, Indonesian, Thai, Vietnamese, etc.) _____

☐ South Asian (Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan) _____

☐ White / European (English, French, Italian, Russian, Polish, Ukrainian, etc.) _____

☐ Other (please specify): _____

☐ Do not know _____

☐ Prefer not to say _____

Did donor egg(s) and/or sperm contribute to this pregnancy?

☐**Yes** ☐**No**

If yes, please specify if they were donor egg, donor sperm, or both.

_____

Do you know the ethnicity of the donor egg(s) and/or sperm?

☐**Yes** ☐**No** ☐ **Not Applicable**

If yes, please specify. _____

Will you be 35 years of age or older at the estimated date of your birth?

☐**Yes** ☐**No**

If yes, how old will you be? _____ years

Have you and/or your partner ever been told that you have thalassemia or sickle cell anemia?

☐**Yes** ☐**No**

If yes, please provide details.

_____

Do you and the baby's father have common relatives?

☐**Yes** ☐**No**

If yes, please provide details.

_____

Are you or baby's father members of any of the following ethnic groups?

☐ Ashkenazi Jewish (Tay Sachs, Canavan, Familial Dysautonomia)

☐ French Canadian from Saguenay Lac-St-Jean, Charlevoix, or Bas-St-Laurent (Tay Sachs, Cystic Fibrosis)

Do either you or the baby's father have a personal or family history of any of the following?

☐ Congenital anomaly (e.g. congenital heart defect, neural tube defect, etc.)

☐ Intellectual disability or developmental delay

☐ Genetic syndrome (e.g. neurofibromatosis, Noonan Syndrome, etc.)

☐ Chromosomal disorder (e.g. trisomy 21, familial translocation, etc.)

☐ Muscular disorder (e.g. X-linked Duchene or Becker muscular dystrophies)

☐ Bleeding disorder (e.g. X-linked hemophilia A or B)

☐ Stillbirth

☐ Sudden unexplained death

☐ Other major health concerns (e.g. cardiomyopathy, neurological disease, epilepsy, autism, etc.)

☐ Unknown

☐ None of the above

If you gave a positive reply for any of the above conditions, please provide additional information below.

PERINATAL MENTAL HEALTH

The next series of questions are part of a Depression Scale to help monitor your mood during your pregnancy and assist you with accessing supports if needed. Please select the answer that represents best how you have felt in the past 7 days.

1. I have been able to laugh and see the funny side of things

- ☐ 0 As much as I always could
- ☐ 1 Not quite so much now
- ☐ 2 Definitely not so much now
- ☐ 3 Not at all

2. I have looked forward with enjoyment to things

- ☐ 0 As much as I ever did
- ☐ 1 Rather less than I used to
- ☐ 2 Definitely less than I used to
- ☐ 3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong

- ☐ 3 Yes, most of the time
- ☐ 2 Yes, some of the time
- ☐ 1 Not very often
- ☐ 0 No, never

4. I have been anxious or worried for no good reason

- ☐ 0 No, not at all
- ☐ 1 Hardly ever
- ☐ 2 Yes, sometimes
- ☐ 3 Yes, very often

5. I have felt scared or panicky for now very good reason

- ☐ 3 Yes, quite a lot
- ☐ 2 Yes, sometimes
- ☐ 1 No, not much
- ☐ 0 No, not at all

6. Things have been getting on top of me

- ☐ 3 Yes, most of the time I haven't been able to cope at all
- ☐ 2 Yes, sometimes I haven't been coping as well as usual
- ☐ 1 No, most of the time I have coped quite well
- ☐ 0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

- ☐ 3 Yes, most of the time
- ☐ 2 Yes, sometimes
- ☐ 1 Not very often
- ☐ 0 No, not at all

8. I have felt sad or miserable

- ☐ 3 Yes, most of the time
- ☐ 2 Yes, quite often
- ☐ 1 Not very often
- ☐ 0 No, not at all

9. I have been so unhappy that I have been crying

- ☐ 3 Yes, most of the time
- ☐ 2 Yes, quite often
- ☐ 1 Only occasionally
- ☐ 0 No, never

10. The thought of harming myself has occurred to me

- ☐ 3 Yes, quite often
- ☐ 2 Sometimes
- ☐ 1 Hardly Ever
- ☐ 0 Never

Thank you for completing this questionnaire.