Are you ready? Only 10 minutes separate you from your pregnancy complications prevention plan. Let's do it!

1. **What is your age?**

* Age:

1. **Please specify your height (in centimetres) and weight (in kilograms)**

* Weight: kgs
* Height: cms

1. **Ethnic origin. Which of the following do you identify with the most?**

□ Asian □ White race □ Middle Eastern/Arab

□ Native American □ Black race □ Latino

□ Other

1. **Have you been pregnant before?**

□ First pregnancy or gestational loss less than 20 weeks

□ Gestational loss > 20 weeks

□ 1 delivery

□ 2 deliveries

□ 3 or more deliveries

1. **Have you required in vitro fertilization/assisted reproduction techniques for your current pregnancy?**

□ Yes

□ No

□ I am not currently pregnant

1. **Is your current pregnancy multiple? (2 or more embryos/foetuses)**

□ Yes □ No □ I am not currently pregnant

1. **Have you been previously diagnosed with deep vein thrombosis AND are you currently taking any anticoagulant treatment?**

□ Yes, I have been diagnosed with deep vein thrombosis AND I am currently on anticoagulant treatment.

□ No, I am not on anticoagulant treatment for a previous deep vein thrombosis.

1. **Have you been previously diagnosed with antithrombin deficiency or antiphospholipid syndrome?**

□ Yes, I have been diagnosed with antithrombin deficiency or antiphospholipid syndrome.

□ No, I have not been diagnosed with antithrombin deficiency or antiphospholipid syndrome.

1. **Have you been previously diagnosed with deep vein thrombosis for which you required anticoagulant treatment in the past? Specify if it was after a surgery.**

□ Yes, I was diagnosed with deep vein thrombosis AND I am NOT currently on anticoagulant treatment (The cause of the thrombosis was a recent surgery).

□ Yes, I was diagnosed with deep vein thrombosis AND I am NOT currently on anticoagulant treatment (The cause of the thrombosis is unknown or different from surgery).

□ No, I have never had deep vein thrombosis.

1. **Have you been previously diagnosed with any of the following thrombophilia? Please specify which:**

|  |  |  |
| --- | --- | --- |
| □ Homozygous factor V Leiden | □ Homozygous prothrombin gene mutation | □ Protein C deficiency |
| □ Heterozygous factor V Leiden | □ Heterozygous prothrombin gene mutation | □ Protein S deficiency |
|  |  | □ Obstetric antiphospholipid syndrome |

1. **Have you been previously diagnosed with any of the following conditions? Please specify which:**

|  |  |  |  |
| --- | --- | --- | --- |
| □ Active cancer (specify): ………………………. | □ Active systemic lupus erythematosus | □ Active heart failure | □ Previous thyroid pathology with current treatment |
| □ Sickle cell anemia or thalassemia | □ Active nephrotic syndrome (renal pathology) | □ Obstetric/thrombotic antiphospholipid syndrome | □ Subclinical hypothyroidism |
| □ Other hemoglobinopathy | □ Chronic hypertension (pre-pregnancy) | □ Polycystic ovary syndrome | □ Previous treatment with radioactive iodine |
| □ Chronic kidney disease | □ Active inflammatory bowel disease | □ Chronic hepatitis C | □ Previous thyroidectomy |
|  | □ Active inflammatory polyarthritis | □ Non-alcoholic fatty liver | □ Goitre |
|  |  | □ Type I diabetes mellitus | □ Previous thyroiditis |
|  |  | □ Type 1 diabetes with renal involvement | □ Previous inflammatory pathology/surgery affecting iron absorption (celiac disease, current H. pylori infection, or inflammatory bowel disease) |
|  |  | □ Type II diabetes |  |

**12- Have you been diagnosed with or do you currently have any of the following? Please check all that apply.**

|  |  |
| --- | --- |
| □ Immobilization (wheelchair, paraplegia)  □ Persistent positivity of antiphospholipid antibodies    □ Positivity of antithyroid antibodies | □ Interval between pregnancies > 10 years  □ Interval between pregnancies < 1 year  □ Insulin resistance or prediabetes  □ Currently on treatment with  corticosteroids or antipsychotics |
| □ Current intravenous drug use  □ Palpable thick venous varices  □ Current smoker | □ Previous pregnancy with a baby weighing >4.5 kg  □ History of liver enzyme abnormalities with oral contraceptives |
| □ Preeclampsia in current pregnancy  □ Hyperemesis gravidarum in current pregnancy | □ Previous intravenous iron therapy  □ Following a vegetarian or vegan diet  □ Recent history of significant bleeding |

**13- Have you experienced any of the following in previous pregnancies? Please specify which one/ones:**

□ Preeclampsia or chronic arterial hypertension

□ Gestational diabetes

□ Hyperemesis gravidarum

□Hypothyroidism/hyperthyroidism

□ Anaemia

□ Intrahepatic cholestasis

□ None of the above

□ I have not been pregnant

**14- Do you have any family history (parents, siblings or children) of any of the following conditions?**

|  |  |  |  |
| --- | --- | --- | --- |
| □ thyroid disorder  Familial autoimmune  □ Preeclampsia | □ Familial genetic thrombophilia (including factor V Leiden, mutation of the prothrombin gene, protein C or S) | □ Mother/sisters or daughters with intrahepatic cholestasis  □ Deep vein thrombosis | □ Mother/sisters or daughters with diabetes mellitus  □ Mother/sisters or daughters with hyperemesis gravidarum |

1. **Evaluation of mental well-being during pregnancy. Please specify which of the following apply to your current situation.**

□ You have been diagnosed with a previous or current psychiatric disorder including schizophrenia, bipolar disorder, obsessive-compulsive disorder, or eating disorder (such as bulimia or anorexia), among others.

□ You are currently undergoing psychiatric treatment with medication (including antidepressants, antipsychotics, mood stabilizers, stimulant medication or anxiety medication, among others).

□ You have had previous suicide attempts.

□ You have a history of psychosis, depression, or anxiety (including previous pregnancies and postpartum).

□ You have a family history (parents, siblings or children) of mental illness (including postpartum psychosis, bipolar disorder, anxiety or depression). □ You have problems living with your current partner.

□ You have current financial problems.

□ You have little or no family or friend support to rely on for the care of your baby.

□ The current pregnancy is unwanted.

1. **Have you experienced any of the following situations regularly (3 or more days per week) in the last month? Please specify which:**

□ You have difficulty concentrating.

□ You get easily angry or irritable.

□ You have difficulty sleeping at night.

□ You constantly feel on edge.

□ You feel anxious or nervous.

□ You can't stop repeatedly thinking about the same thing.

□ You are afraid that something bad will happen during your pregnancy.

□ You have constant negative thoughts.

□ You feel guilty about the problems you're currently experiencing.

□ Loss of interest in the people around you or everyday activities.

□ You feel sad, down or more easily prone to tears.