British Columbia Antenatal Record Part 1

1. Primary maternity care provider name | Family physician/nurse practitioner name

Patient surname | Patient given name(s) | Date of birth (dd/mm/yyyy) | Age at EDD

Surname at birth | Preferred name/pronoun | Language preferred | Relationship status*

Highest level of education completed* | Occupation

Indigenous identity:* ☐ First Nations ☐ Métis ☐ Inuk (Inuit) ☐ Status ☐ Non-status ☐ No response ☐ None

☐ Live on reserve ☐ Live off reserve ☐ Live on & off reserve

Ethnicity*

Partner: Surname, given name(s) | Occupation

Biological father/donor: Surname, given name(s) OR ☐ Same as partner | Age | Ethnicity*

Surname Given name

Address

Phone number

Personal Health Number

2. Allergies (incl. reaction) ☐ None | Medications/OTC drugs/herbals/vitamins ☐ Preconception folic acid ☐ T1 folic acid | Beliefs/practices (e.g. Jehovah's Witness)

3. Contraceptives: Type | Last used (dd/mm/yyyy) | Pregnancy planned: ☐ No ☐ Yes | LMP (dd/mm/yyyy) | EDD by LMP (dd/mm/yyyy) | Dating US (dd/mm/yyyy) | GA by US (wks/days) | EDD by US (dd/mm/yyyy)

4. Obstetrical History **G**ravida _____ **T**erm _____ **P**reterm _____ **A**bortus (Induced _____ Spontaneous _____) **L**iving _____

Date (mm/yyyy)	Place of birth	GA (wks/days)	Duration of labour (hrs)	Mode of birth	Perinatal complications/comments	Sex	Birth weight (g)	Breastfed (mos)	Child's present health

5. Present Pregnancy

No Yes (specify)

- ☐ ☐ ART: (select one only)
  - ☐ Ovarian stimulation only
  - ☐ IUI only
  - ☐ Ovarian stimulation + IUI
  - ☐ IVF (# of embryos transferred) _____
  - ☐ ICSI (# of embryos transferred) _____
  - ☐ Other _____
- ☐ ☐ Bleeding _____
- ☐ ☐ Nausea _____
- ☐ ☐ Travel (self/partner) _____
- ☐ ☐ Infection/rash/fever _____
- ☐ ☐ Other _____

6. Family History

No Yes (specify)

- ☐ ☐ Anesthetic complications _____
- ☐ ☐ Hypertension _____
- ☐ ☐ Thromboembolic _____
- ☐ ☐ Diabetes _____
- ☐ ☐ Mental health _____
- ☐ ☐ Substance use disorder _____
- ☐ ☐ Inherited conditions/defects (e.g. Tay-Sachs, Sickle Cell, Congenital Heart Defect, Cystic Fibrosis)
  (Mother) _____
  (Biological father/donor) _____
- ☐ ☐ Other _____

7. Medical History

No Yes (specify)

- ☐ ☐ Surgery _____
- ☐ ☐ Anesthetic complications _____
- ☐ ☐ Neuro. _____
- ☐ ☐ Resp. _____
- ☐ ☐ CV: ☐ Hypertension ☐ Prev. hypertension in preg. ☐ Other _____
- ☐ ☐ Abdo./GI _____
- ☐ ☐ Gyne./GU _____
- ☐ ☐ Hematology (e.g. transfusion, thromboembolic/coag.) _____
- ☐ ☐ Endocrine: ☐ T1DM ☐ T2DM ☐ Prev. GDM ☐ Thyroid ☐ Other _____
- ☐ ☐ Mental health: ☐ Anxiety ☐ Depression ☐ Prev. PPD ☐ Bipolar ☐ Eating disorder ☐ Substance use disorder: ☐ Methadone treatment ☐ Suboxone treatment ☐ Other _____
- ☐ ☐ Infectious diseases: ☐ Varicella ☐ HSV ☐ Other _____
- ☐ ☐ Immunizations: ☐ Flu (dd/mm/yyyy) _____ ☐ Tdap (dd/mm/yyyy) _____ ☐ Other _____
- ☐ ☐ Other _____

8. Lifestyle/Social Concerns

No Yes (specify)

- ☐ ☐ Diet/nutrition _____
- ☐ ☐ Exercise _____
- ☐ ☐ Financial _____
- ☐ ☐ Housing/food security _____
- ☐ ☐ Transportation _____
- ☐ ☐ Safety _____
- ☐ ☐ Gender-based violence: ☐ Partner ☐ Non-partner
- ☐ ☐ Relationships/support _____
- ☐ ☐ Other _____

9. Substance Use

	3 Mos Before Preg	During Preg
Alcohol	☐ No ☐ Yes	☐ No ☐ Yes
# Drinks per week	_____	_____
4 or more drinks at one time	☐ No ☐ Yes	☐ No ☐ Yes
Quit alcohol: ☐ No ☐ Yes, date (dd/mm/yyyy) _____		
Tobacco	☐ No ☐ Yes	☐ No ☐ Yes
# Cigarettes per day	_____	_____
Exposed to 2nd-hand smoke	☐ No ☐ Yes	☐ No ☐ Yes
Quit tobacco: ☐ No ☐ Yes, date (dd/mm/yyyy) _____		
Cannabis	☐ No ☐ Yes	☐ No ☐ Yes
CBD product(s) only	☐ No ☐ Yes	☐ No ☐ Yes
# Times used per (circle to specify)	_____ day week month	_____ day week month
Primary route: (select one only)	☐ Smoke ☐ Vaporize ☐ Edible/oral ☐ Other	☐ Smoke ☐ Vaporize ☐ Edible/oral ☐ Other
Quit cannabis: ☐ No ☐ Yes, date (dd/mm/yyyy) _____		
Other(s) During Preg	☐ No ☐ Yes: (check all that apply)	
☐ Cocaine ☐ Opioids ☐ Methamphetamines ☐ IV drugs ☐ Prescription drugs ☐ Other(s) _____		

10. Initial Physical Examination Date (dd/mm/yyyy) _____ Completed by (name) _____

BP | HR (per min) | Ht (cm) | Pre-preg. Wt* (kg) | Pre-preg. BMI*

Norm Abnorm (specify)

- ☐ ☐ Head & neck _____
- ☐ ☐ Breasts & nipples _____
- ☐ ☐ Heart & lungs _____
- ☐ ☐ Abdomen _____
- ☐ ☐ Musculoskeletal _____
- ☐ ☐ Skin: ☐ Varicosities ☐ Other _____
- ☐ ☐ Pelvic _____
  STI test (dd/mm/yyyy) _____
  Pap test (dd/mm/yyyy) _____
- ☐ ☐ Other _____

11. Comments/Follow-up (incl. details from sections 5–10)

Care provider (signature) _____ ☐ MD ☐ RM ☐ NP

** Please refer to **Reference Page 1** on the back of this page for guidance and a list of discussion topics.*