Office Use Only
Adult ID #: _____

Pregnancy Health Questionnaire

Today's Date (Month-Day-Year)	**Partial Date of Birth (Month-Year)**
Due Date (Month-Day-Year)	**Pre-Pregnancy Weight (kg)**

Have you participated in this study previously?

- ☐ No
- ☐ Yes. Please specify when: _____.

Country of Birth

- ☐ Canada
  - → Please indicate province: _____
- ☐ Other Country (Please specify): _____
  - → How long have you lived in Canada? _____

Maternal Ethnicity	**Paternal Ethnicity**
☐ Aboriginal	☐ Aboriginal
☐ Arab/West Asian	☐ Arab/West Asian
☐ Black	☐ Black
☐ Chinese	☐ Chinese
☐ Filipino	☐ Filipino
☐ Japanese	☐ Japanese
☐ Korean	☐ Korean
☐ Latin American	☐ Latin American
☐ South Asian (e.g. West Indian, Guyanese, India, Pakistan, Bangladesh, Afghanistan, etc.)	☐ South Asian (e.g. West Indian, Guyanese, India, Pakistan, Bangladesh, Afghanistan, etc.)
☐ South East Asian (e.g. Burma, Cambodia, Thailand, Vietnam, Singapore, etc.)	☐ South East Asian (e.g. Burma, Cambodia, Thailand, Vietnam, Singapore, etc.)
☐ Caucasian	☐ Caucasian
☐ Other: _____	☐ Other: _____
☐ Unknown	☐ Unknown
☐ Prefer not to answer	☐ Prefer not to answer

SickKids

MARCH OF DIMES

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Is your doctor monitoring you for a condition/abnormality?

- ☐ No
- ☐ Yes – Please Explain: _____

Have you been seriously ill within the <u>past 7 days (i.e. bad cold/flu with fever, etc)</u>?

- ☐ No
- ☐ Yes – Please Explain:_____

Do you regularly take any prescribed medication(s)?

- ☐ Anxiety/Depression Medication
- ☐ ADHD/ADD Medication
- ☐ Asthma Medication
- ☐ Thyroid Medication
- ☐ **Other** – Please Explain: _____
- ☐ No, I do not regularly take prescribed medications

Do you regularly take any supplement(s)?

- ☐ Prenatal supplement – Please specify brand:_____
- ☐ Folic acid
- ☐ Iron
- ☐ Vitamin D
- ☐ **Other** – Please Explain: _____
- ☐ No, I do not regularly take supplements

Please indicate ALL non-prescribed medications or substances that you have taken in the <u>past 7 days</u>.

- ☐ **Cold or Flu Medications** (e.g. Tylenol Cold, Cough and Flu, Decongestants, Cough Syrup, etc.)
- ☐ **Ibuprofen** (Advil) / **Acetaminophen** (Tylenol) / **Acetylsalicylic Acid** (Aspirin)
- ☐ **Allergy Medication** (Antihistamines – e.g. Benadryl, Reactine, etc.)
- ☐ **Other**– Please Explain:_____
- ☐ No non-prescribed medications or substances have been taken in the past 7 days

During your pregnancy, have you consumed any of the following?

- ☐ Cigarettes
- ☐ More than 1 alcoholic drink per week
- ☐ **Other** – Please Explain:_____.
- ☐ None of the above were consumed

Please indicate the method of conception for this pregnancy.

- ☐ Natural
- ☐ Other. Please Explain:_____.

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Height: _____ (cm)
Weight: _____(kg)
Hours since last meal: _____ (hours)