OBSTETRICS & GYNECOLOGY
DR. VASSILIOU
M.D., F.R.C.S.C.

NEW OB REGISTRATION FORM (Confidential)

First Name: _____Last Name: _____ Date of Birth: _____

OHIP: __ __ __ __ __ __ __ __ __ __ Code: __ __ Expiration Date: _____ Age: _____

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Tel: _____ Work Tel.: _____ Ext.:_____ Cell: _____

Employer: _____ Occupation: _____

Email: _____ Status: Single ☐ Common-law ☐ Married ☐

Reason for Visit: _____

Referring Physician: _____ Physician's Tel.: _____

Family History		
	List Illnesses (Cancer, Diabetes, Heart Disease, High Blood Pressure, Blood Clots, Thyroids, Anesthetic complications, Mental health, etc.)	**Age**
Father		
Mother		
Brothers		
Sisters		

Past History	
Operations you have had:	Year
Illnesses that required hospitalization:	Year
Illnesses not requiring hospitalization:	Year

List present medications: _____

Have you had an allergic reaction to any medication? _____

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Gynecological History

Age of onset of menstruation: _____ Date of last normal menstrual period: _____

How long does you period last? _____Every how often do you have a period? _____

Do you ever have bleeding between periods? _____ Date of last Pap smear? _____

Method of contraception used? _____ Date of last mammogram? _____

Have you ever had any gynecological problems? Y/N

Comments:_____

Have you ever been pregnant before? _____

Year	Sex	Gestation Wks.	Weight	Place of Birth	Vag./C-section	Duration of Labour	Complications

Medical History (please circle yes or no to each of the following)

Current Pregnancy

Bleeding Y/N
Nausea/vomiting Y/N
Rash/fever/illness Y/N

Nutrition

Calcium adequate Y/N
Vitamin D adequate Y/N
Folic acid preconception Y/N
Prenatal vitamin Y/N
Food access/quality adequate Y/N
Dietary restrictions Y/N

Surgical History

Surgery Y/N
Anaesthetic complications Y/N

Medical History

High blood pressure Y/N
Heart disease Y/N
Hormone problems Y/N
Gastrointestinal / Liver Y/N
Breast (incl. surgery) Y/N
Gynecological (incl. surgery) Y/N
Urinary tract Y/N
Muscle and bone/ Rheumatology Y/N
Hematological Y/N
Blood clots Y/N
Blood transfusion Y/N
Neurological Y/N
Other _____

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Genetic History

Ethnic/racial background: Mother _____ / Father _____ Age _____

Are there any of the following in your background? Y/N

- Hemoglobinopathy screening (Asian, African, Middle Eastern, Mediterranean, Hispanic, Caribbean) Y/N
- Tay-Sachs disease screening (Ashkenazi Jewish, French Canadian, Acadian, Cajun) Y/N
- Ashkenazi Jewish screening panel Y/N

Genetic Family History

- Genetic conditions (cystic fibrosis, muscular dystrophy, chromosomal disorder) Y/N
- Other (eg. Intellectual, birth defect, heart disease, development delay, recurrent pregnancy loss, stillbirth) Y/N
- Are you related to your partner? Y/N

Infectious Disease

Chicken pox	Y/N	Genital herpes Y/N - Partner	Y/N
Chicken pox vaccine	Y/N	Sexually Transmitted Disease	Y/N
HIV	Y/N	Other _____	

Mental Health / Substance Use

Anxitey	Past Y/N	Present Y/N
Depression	Past Y/N	Present Y/N
Eating disorder	Y/N	
Bipolar disease	Y/N	
Schizophrenia	Y/N	
Other (eg. PTSD, ADD, personality disorders)	Y/N	
Smoked cig within past 6 months	Y/N	Current smoking _____ cig/day
Alcohol: Ever drink alcohol?	Y/N	If yes: Last drink (when) _____ Current drinking _____ drinks/wk
Marijuana	Y/N	
Non-prescribed substances/drugs	Y/N	

Lifestyle/ Social

Occupational risks	Y/N
Financial/housing issues	Y/N
Poor social support	Y/N
Relationship problems	Y/N
Intimate partner/family violence	Y/N

Are you a Primary School Teacher/ Run or a Caregiver in a daycare? _____

Patient's Signature: _____ Date: _____

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Ontario

Ministry of Health and Long-Term Care

Resources

Last Name	First Name

Anxiety Screening

Generalized Anxiety Disorder scale (GAD-2) Date YYYY/MM/DD

Over the last 2 weeks, how often have you been bothered by the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not been able to stop or control worrying	0	1	2	3

A total score of 3 or more warrants consideration of: Using the GAD-7 for further assessment or additional mental health follow-up.

Total Score ____

Depression Screening

The Patient Health Questionnaire-2 (PHQ-2) Date YYYY/MM/DD

Over the last 2 weeks, how often have you been bothered by the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

A total score of 3 or more warrants consideration of: Using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ) 9 for further assessment or additional mental health follow-up.

Total Score ____

T-ACE Screening Tool (Alcohol)

Response Key

1 Drink is equivalent to:

• 12 oz of beer • 12 oz of cooler • 5 oz of wine • 1.5 oz of hard liquor (mixed drink)

Date YYYY/MM/DD

	Response	
1. How many drinks does it take to make you feel high?	≤ 2 drinks = **0**	> 2 drinks = **1**
2. Have people annoyed you by criticizing your drinking?	No = **0**	Yes = **1**
3. Have you felt you ought to cut down on your drinking?	No = **0**	Yes = **1**
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	No = **0**	Yes = **1**

A total score of 2 or greater indicates potential prenatal risk and need for follow-up.

Total Score ____

Edinburgh Perinatal / Postnatal Depression Scale (EPDS) Cox, Holden, Sagovsky, (1987).

In the past 7 days:

Date YYYY/MM/DD

1. I have been able to laugh and see the funny side of things	☐ As much as I always could = **0** ☐ Not quite so much now = **1**	☐ Definitely not so much now = **2** ☐ Not at all = **3**
2. I have looked forward with enjoyment to things	☐ As much as I ever did = **0** ☐ Rather less than I used to = **1**	☐ Definitely less than I used to = **2** ☐ Hardly at all = **3**
3. I have blamed myself unnecessarily when things went wrong	☐ No, never = **0** ☐ No, not very often = **1**	☐ Yes, some of the time = **2** ☐ Yes, most of the time = **3**
4. I have been anxious or worried for no good reason	☐ No, not at all = **0** ☐ Hardly ever = **1**	☐ Yes, sometimes = **2** ☐ Yes, very often = **3**
5. I have felt scared or panicky for no very good reason	☐ No, not at all = **0** ☐ No, not much = **1**	☐ Yes, sometimes = **2** ☐ Yes, quite a lot = **3**
6. Things have been getting on top of me	☐ No, I have been coping as well as ever = **0** ☐ No, most of the time I have coped well = **1**	☐ Yes, sometimes I haven't been coping as well as usual = **2** ☐ Yes, most of the time I haven't been able to cope = **3**
7. I have been so unhappy that I have had difficulty sleeping	☐ No, not much = **0** ☐ Not very often = **1**	☐ Yes, sometimes = **2** ☐ Yes, most of the time = **3**
8. I have felt sad or miserable	☐ No, not much = **0** ☐ Not very often = **1**	☐ Yes, quite often = **2** ☐ Yes, most of the time = **3**
9. I have been so unhappy that I have been crying	☐ No, never = **0** ☐ Only occasionally = **1**	☐ Yes, quite often = **2** ☐ Yes, most of the time = **3**
10. The thought of harming myself has occurred to me	☐ No, never = **0** ☐ Only occasionally = **1**	☐ Yes, quite often = **2** ☐ Yes, most of the time = **3**

Total Score ____

Score of 1-3 on item 10 indicates a risk of self-harm. Patient requires immediate mental health assessment and intervention as appropriate.

Score > 9 Monitor, support, and offer education

Score > 12 Follow up with comprehensive bio-psychosocial diagnostic assessment for depression.

Institute of Medicine Weight Gain Recommendations for Pregnancy (2009)

Prepregnancy Weight Category	Body Mass Index	Recommended range of Total Weight in kg (lb)	Rates of Weight Gain in Second and Third Trimesters	
			kg/wk	lb/wk (mean range)
Underweight	Less than 18.5	12.5-18 kg (28-40)	0.5	1 (1-1.3)
Normal Weight	18.5-24.9	11.5-16 kg (25-35)	0.4	1 (0.8-1)
Overweight	25-29.9	7-11.5 kg (15-25)	0.3	0.6 (0.5-0.7)
Obese (includes all classes)	30 and greater	5-9 kg (11-20)	0.2	0.5 (0.4-0.6)

†Calculations assume a 0.5 to 2 kg (1.1-4.4 lb) weight gain in the first trimester.

