Shared health
Soins communs
Manitoba

Genetics & Metabolism Program
Birth History Form

Appointment with: ________________________ **Appointment date:** _____________________________

Patient legal name: _________________________ **Patient preferred name:** _____________________

Date of birth: ______________________________ **PHIN:** ____________________________________

Sex assigned at birth: Male / Female / Unassigned ____________ **Gender:** _______________________

Patient pronouns (she/her, he/him, they/them, etc): ____

Please list the full names and locations of any medical specialists that the referred patient has seen (please list the type of doctor or medical specialty): ____

____

Prenatal History

During which month of pregnancy did the referred patient's mother/pregnancy carrier start prenatal care?

____

Any ultrasounds during the pregnancy? (Y/N) If so, at what stage(s) of the pregnancy? _________________

Please list drugs, medications and supplements taken during pregnancy (Including vitamins, supplements, prescription medication, over-the-counter medication). List the dose if known, and when in pregnancy it was taken.

Any alcohol use during the pregnancy? (Y/N) ____

Any cigarette use during the pregnancy? (Y/N) ____

Any medication use during the pregnancy? (Y/N) Type? ____

Any street drug use during the pregnancy? (Y/N) Type? ____

Did the referred patient's mother/pregnancy carrier have any serious illnesses during pregnancy, such as: fever, rashes, infections, vaginal bleeding, high blood pressure, excessive vomiting, accidents, operations, or any other concerning condition in the pregnancy? If so, please list:

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____

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Birth History

Was baby full term? (Yes/No) Delivered at how many weeks? ______

Hospital/place of delivery: ____________________

Presentation: Head first? (Y/N) Breech (feet first)? (Y/N) Other: ________________________________

Was anesthetic used? (Y/N) What kind? ____

Vaginal delivery or Caesarian section? (circle one) Forceps? (Y/N) Suction? (Y/N)

Single birth? (Y/N) Twins? (Y/N) If twins, 1st or 2nd born? _______Other:__________________________

Please list any complications during the delivery: ____

Did the baby breathe immediately? (Y/N) Cry immediately? (Y/N) Need oxygen treatment? (Y/N)

Birth weight:_____________ Birth length: ___________ Head circumference: __________

Apgars score (if known) 1 min:________ 5 min: ________

Any problems during the 1st week of life? (jaundice, respiratory distress, feeding problems, birth defects, seizures, etc)? ____

Length of mother/pregnancy carrier's hospital stay: _______________ Length of baby's hospital stay: __________________

Did the referred patient have a different first or last name at birth? (Y/N) If so, what was it? _____________

Who is the referred patient's pediatrician? ____

Developmental Milestones & Education

When did the referred patient first:

Hold head up?	________ months	Smile responsively?	________ months
Sit without support?	________ months	Crawled?	________ months
Walk without support?	________ months	Say first words?	________ months
Spoke in a sentence?	________ months	Potty trained?	________ months

Is the referred patient going to school? (Y/N) If so, what grade? __________ (Regular / special classes)

Does the referred patient have an educational assistant (EA) or an individualized education plan (IEP)? (Y/N)

If yes, please describe: ____

Were their most recent school grades average, below average, or above average? __________________

Are there concerns about the referred patient's performance in school? (Y/N)

Does the referred patient have a social worker or Children's Special Services? (Y/N)

Name: _______________________ PHIN: _______________________