Well-being Health History

This helps us know how best to support you and understand if you might be at greater risk of struggling during pregnancy or the postpartum period (the year after childbirth), or suffering from a maternal mental health condition.
We are here to help.

Are you aware of a **personal or family history of mental health challenges?**
If so, let us know who? (circle all that apply):
SELF MOM DAD SISTER(S) BROTHER(S) GRANDMOTHER(S) GRANDFATHER(S) AUNT(S) UNCLE(S)

If you've circled any of the above, please **share which disorders or challenges you or a family member experienced** on the line below.

These could include a range of challenges, such as:

Depression	WHO: _____
Anxiety	WHO: _____
OCD	WHO: _____
Intrusive unwanted thoughts	WHO: _____
Eating disorder	WHO: _____
Bipolar disorder (I or II)	WHO: _____
Schizophrenia	WHO: _____
Personality disorders (like borderline personality disorder)	WHO: _____
Non-Suicidal Self-Harm (like cutting)	WHO: _____
PTSD	WHO: _____
Severe Mental Illness (like schizophrenia)	WHO: _____
Substance use disorder (such as high alcohol or cannabis intake, opioid RX or illicit drug use)	WHO: _____
Other	WHO:_____

Please share anything else that would be helpful for us to know (for example, maybe you or a family member hasn't been formally diagnosed with any of the above but there have been symptoms):
_____

If **you** have experienced one or more of the challenges or conditions above, **have you received treatment before?** If so, **please share the type of treatment**, such as seeing a therapist or trying a prescription drug like Zoloft. Leave blank if you haven't had treatment for the disorder/challenge.

Depression	Treatment: _____	Current □ Previous □
Anxiety	Treatment: _____	Current □ Previous □
OCD	Treatment: _____	Current □ Previous □
Intrusive unwanted thoughts	Treatment: _____	Current □ Previous □
Eating disorder	Treatment: _____	Current □ Previous □
Bipolar disorder (I or II)	Treatment: _____	Current □ Previous □
Schizophrenia	Treatment: _____	Current □ Previous □
Personality disorders (like borderline personality disorder)	Treatment: _____	Current □ Previous □
Non-Suicidal Self-Harm (like cutting)	Treatment: _____	Current □ Previous □
PTSD	Treatment: _____	Current □ Previous □
Severe Mental Illness (like schizophrenia)	Treatment: _____	Current □ Previous □
Substance use challenges (such as high alcohol or cannabis intake or illicit drug use)	Treatment: _____	Current □ Previous □
Other _____	Treatment:_____	Current □ Previous □

Are you currently under the care of a psychiatrist (who prescribes drug treatments for any of the above) or therapist? If so please provide their name(s) (and phone number if you have it):

_____

_____

Fertility History

Did you have difficulty conceiving?

Have you received infertility treatment? □YES □NO

If so, what type of treatment and for how long?

_____

Metabolic History

Have you or an immediate family member (mom, dad, sister, etc.) experienced:

Polyendocrine Metabolic Ovarian Syndrome (PMOS)	□YES □NO □Unsure
Diabetes (Type 2)	□YES □NO □Unsure
Prediabetes	□YES □NO □Unsure
Metabolic Syndrome (MetS)	□YES □NO □Unsure
(3 or more of the following conditions: obesity, diabetes, hypertension, low HDL or high LDL) Thyroid disorder (s)	□YES □NO □Unsure
Dyslipidemia (High Cholesterol/Triglycerides)	□YES □NO □Unsure
Liver Disease	□YES □NO □Unsure
History of Maternal Hypertension / Pre-eclampsia:	□YES □NO □Unsure
PKU or Wilson's Disease	□YES □NO □Unsure

Sleep

Do you have a history of sleep difficulties outside of pregnancy or the postpartum? □YES □NO

Please explain:

_____

Breastfeeding History and Hopes

Have you tried breastfeeding in the past? □YES □NO □NA

If so, how did it go?

_____

Do you plan to breastfeed with this pregnancy? □YES □NO □Unsure

Prior Pregnancies/Births

Have you had prior pregnancies? □YES □NO If so, how many? _____ (regardless of outcome)

Did you find that your pregnancy, birthing or postpartum experiences were complicated, severe or traumatic?

□YES □NO If yes, please explain

_____

Have you had a miscarriage, stillbirth or loss of an infant □YES □NO □NA

Do you have other children in the home? □YES □NO If so, how many and what ages?

_____

Partner, and Family & Friend Network

What's your current relationship status, do you have a partner? Circle what applies:

SINGLE MARRIED WIDOWED

COMMITTED-RELATIONSHIP-LIVING-TOGETHER

COMMITTED-RELATIONSHIP-NOT-LIVING-TOGETHER

Do you have a family and/or friend network (e.g., individuals you can count on for practical help and/or to talk through difficulties)? □YES □NO

Please Explain:

_____

Do you feel you could ask your partner, family, or friend network for practical help and/or to talk through difficulties?

Please explain

_____

Misc. Insights that Can Impact Your Mental Health and Well-Being

We ask these questions, as we are here to get you support and treatment if needed.

Are your partners (circle): MEN WOMEN BOTH OTHER NONE □ Prefer not to answer

Do you currently use tobacco or vape? □YES □NO □ Prefer not to answer

If yes, how much/how often?_____

Do you currently drink alcohol? □YES □NO□ Prefer not to answer

If yes, how much/how often?_____

Do you currently use cannabis or cannabis products like CBD? □YES □NO □ Prefer not to answer
If yes, how much/how often?_____
Do you have concerns about drug use and want help? □YES □NO
Do you have guns in your home? □YES □NO □ Prefer not to answer
Have you ever been a victim of unwanted sexual pressure, sexual abuse, or sexual violence? □YES □NO □ Prefer not to answer
Do you currently feel physically safe at home? □YES □NO □ Prefer not to answer
Are you concerned about where you will live or get your next meal? □YES □NO □ Prefer not to answer
Do you have concerns about eating and/or pregnancy, weight gain or loss? □YES □NO □ Prefer not to answer