Pregnancy-Related Cardiovascular Risk Indicators

Indicator	
Preeclampsia	☐
Gestational Hypertension	☐
Gestational Diabetes	☐
Gestational Impaired Glucose Tolerance	☐
Placental Abruption	☐
Excessive Weight Gain in Pregnancy	☐
Preterm Birth	☐
Intrauterine Growth Restriction	☐

If you are unsure whether you experienced any of the above complications during this or a previous pregnancy ask your family physician or obstetrician at your next follow up appointment.

For assistance filling out any section of the health record and/or for definitions of terms used in the health record please visit:

www.themothersprogram.ca

Personal and Family History

With which ethnicity do you identify?

- ☐ Caucasian
- ☐ African
- ☐ Asian
- ☐ Southeast Asian
- ☐ Metis/First Nations/Inuit
- ☐ Other ________________________

Question	
Are you a smoker?	Yes / No
Personal history of heart attack or stroke?	Yes / No
Personal history of high blood pressure?	Yes / No
Personal history of diabetes?	Yes / No
Family history of preeclampsia (toxemia) or high blood pressure in pregnancy ?	Yes / No
Family history of high blood pressure?	Yes / No
Family history of heart attack or stroke?	Yes / No
Family history of diabetes?	Yes / No

MoTHERS Post Partum Health Record©

Name

____

Mother's Date of Birth

____

YYYY / MM / DD

Mother's Ontario Health Card Number

____

Date of Delivery

____

YYYY / MM / DD

Your baby's check-ups and immunizations are a great time to fill out this record with your doctor! Keep this form with your baby's immunization record for an easy reminder.

Recommended Health Check-Up Schedule

Time Since Delivery	Date of Completion (yyyy-mm-dd)	Weight[a] (lbs or kg)	Waist Circumference (cm)	Body Mass Index[b] (kg/m^2)	Blood Pressure (mmHg)	Activity Level (sedentary/mild/ moderate/ strenuous)	Breast-feeding (Yes/No)	2 Hour 75g OGTT [c] (mmol/L)	HDL[d] (mmol/L)	LDL[d] (mmol/L)	Choles-terol[d] (mmol/L)	Triglyc-erides[d] (mmol/L)	Glucose[d] (mmol/L)	High Sensitivity CRP (mg/L)
6 Weeks					/									
2 Months					/									
4 Months					/									
6 Months					/			Fasting ___ 1 Hour ___ 2 Hour ___						
12 Months					/									

Pre-pregnancy Weight[a]		lbs or kg
Weight at Delivery[a]		lbs or kg
Goal Weight for 6 Months Post Partum[a]		lbs or kg
Height[a]		inches or cm

Current Medications		
6 Weeks	6 Months	12 Months

a - Please circle the units used
b - BMI = Weight in kg / (Height in metres)^2
c - Recommended for women who developed gestational diabetes during their pregnancy
d - Blood work should be completed after a minimum of a 12 hour fast