

Pregnancy Passport ^{cdn}

Adapted from the MoHERS Program

Pregnancy can be nature's stress test on your health, including your heart. The best timepoints to be screened for heart disease and diabetes risk factors can be during the pregnancy and the postpartum periods.

Did you know?

A history of high blood pressure and/or gestational diabetes in pregnancy does not mean you will definitely develop heart and diabetes problems, but you should have your current and future heart health and blood sugars monitored to reduce such risk.

Women with high blood pressure during pregnancy have a higher incidence of future health events.

2x Heart Disease

2x Stroke

4x High Blood Pressure

2x Kidney Disease

3x Diabetes

2x Venous Thromboembolism

How can you lower your risk?



Stay active. Exercise for at least 150 minutes per week at a moderate intensity. Aim for at least 7,000 steps per day.



Monitor your body weight. Try to stay at the body weight at which you feel the healthiest. This will vary from person-to-person and is not necessarily reflected by the scale or tape measure.



Live smoke and substance free. Reduce or eliminate tobacco, cannabis, and alcohol use.



Breastfeed. If you are able and choose to breastfeed, try to do so as long as possible.



Eat a diverse diet rich in colorful fruits and vegetables, including nuts and seeds. Reduce salt, fat, and sugar intake.



Get at least 6 hours of sleep regularly. Uninterrupted sleep is best for your health, however, may be a challenge with young children. Prioritize your sleep when possible.



See your primary care provider for routine appointments.



Space your next pregnancy, optimize your health before the next pregnancy and seek early attention when you become pregnant.

Your background information

With which ethnicity do you identify? Select all that apply.

- White Black Asian Indigenous
 Other:

Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have high blood pressure before pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have diabetes before pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a heart attack or stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your mother or sister(s) had preeclampsia (toxemia) or high blood pressure during pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your mother, father or any sibling have high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your mother, father or any sibling have diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your mother, father or any sibling ever had a heart attack or stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you had the following pregnancy-related cardiometabolic risk indicators?

If you are unsure whether you experienced any of the above complications, please ask your healthcare provider.

Preeclampsia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gestational Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gestational Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Placental Abruption	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained Preterm Birth (before 37 weeks)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fetal Growth Restriction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stillbirth/Intrauterine Death	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you have any “YES” in your background or risk indicators, **you are at risk.**

For more information

- 1) scan the QR code, or
- 2) visit <https://cwhhc.ottawaheart.ca/PregnancyPassport>



Blood Pressure Check-Up Schedule

Aim for a blood pressure of 120/80

Time since delivery	Average Blood Pressure (mmHg)*	Are you taking Blood Pressure Medication?
1 week <i>Date:</i>	____/____	<input type="checkbox"/> Yes
____ weeks <i>Date:</i>	____/____	<input type="checkbox"/> Yes
____ weeks <i>Date:</i>	____/____	<input type="checkbox"/> Yes
____ weeks <i>Date:</i>	____/____	<input type="checkbox"/> Yes
2 months <i>Date:</i>	____/____	<input type="checkbox"/> Yes
4 months <i>Date:</i>	____/____	<input type="checkbox"/> Yes
6 months <i>Date:</i>	____/____	<input type="checkbox"/> Yes

[Click here](#) to learn more about how to take your blood pressure at home or in a pharmacy.

**If your blood pressure is over 135/85, discuss it with your healthcare provider, make sure to take your medication regularly (if prescribed).*

Recommended 6 Month Assessments

Test	Your Result	Discuss with doctor if...
Total Cholesterol	mmol/L	Over 5.16
HDL	mmol/L	Under 1.3
LDL	mmol/L	Over 3.7
Triglycerides	mmol/L	Over 1.7
Hemoglobin	g/dL	Under 110
Fasting Glucose	mmol/L	Over 6.0 or under 3.6
HbA1c	%	Over 5.6
75g Oral Glucose Tolerance Test	Fasting: mmol/L	Over 5.2
	2Hr: mmol/L	Over 7.8
High Sensitivity CRP	mg/L	Over 4.9
Urine Microalbumin Creatinine Ratio	mg/mmol	Over 2.9
eGFR	mL/min	Under 61

