geboortecentrum PUUR

First Check Obstetrician Form

It is important that the obstetrician is familiar with your medical background. The information gathered on this form will help in enabling the obstetrician to react to your individual situation.
This form contains a number of questions relating to your medical past, your menstrual cycle, your family's medical background, etc. During the pregnancy check, the obstetrician will go through this form with you. It would be greatly appreciated if you could complete the requested information, print out the document and bring it to your first appointment with the Geboortecentrum obstetrician. Thanks in advance and see you then!

* Please enter N/A if not applicable.

Personal data:

Your Data ⇒ *Please bring a valid form of ID to the first check*	Full name: Initials: Maiden Name: Date of Birth: Street & Number: Postal code: Town/City: Telephone No.: Mobile Telephone No.: Marital Status: Profession: Religion: Ethnicity: Name of GP: *(Please bring a valid form of ID to the first check)*
Partner's Data	Full Name: Initials: Surname: Date of Birth: Mobile Telephone No.: Profession:

Pregnancy History:

Is this your first pregnancy? ⇒ *If possible, bring information of your previous pregnanc(y)ies and birth(s) to the first check.*	Yes/No * If no: Fill in the number below: Number of Births: Number of Children: Number of Miscarriages: Number of Abortions:
Is this a planned pregnancy?	Yes/No *

Menstrual Cycle:

What was the first day of your last menstruation?	…… - …… 20…… / I do not know
Was this a normal menstruation?	Yes/No * If no: Why was your menstruation different this time?
Did you have a regular cycle?	Yes/No * If yes: How many days does your cycle usually last?
Have you ever used contraception?	Yes/No * If yes: What type? When did you stop using it?
When did your pregnancy test first show a positive result?	…… - …… 20……
Have you already had an ultrasound?	Yes/No * *If yes: Bring the result to the first check.*

Medical Data:

What is your length?	…… cm.
How much did you weigh before you became pregnant?	…… kg.
Have you ever had surgery?	Yes/No * If yes: What type of surgery have you had? When?
Have you ever been treated by a medical specialist?	Yes/No * If yes: What for? When?
Do you have a (returning) disease or a complaint for which you are currently being treated by your GP?	Yes/Not * If yes: What type of disease or complaint?
Have you ever had a blood transfusion?	Yes/No * If yes: What was the reason? When?
Have you ever had a bladder infection?	Yes/No * If yes: How often have you had this? When?
Have you ever received a negative result after a cervic PAP test?	Yes/No * If yes: What PAP was it? What treatment have you had?
Have you ever had a vaginal yeast infection?	Yes/Not * If yes: How often have you had this? When?
Have you ever had a venereal (sexually transmitted) disease?	Yes/No * If yes: Which disease? When? How were you treated?

Have you ever had negative experiences in the area of sexual violence (such as assault, rape, incest) or home violence?	Yes/No * *If yes: During the first check we will discuss with you to what extent this has an influence on how you experience your pregancy and birth.*
Have you ever had thrombosis or pulmonary embolism? Or do you have another blood clotting disorder?	Yes/No * If yes: What and when? How were you treated?
Have you or your partner ever had herpes labialis?	Yes, I have / Yes, my partner has / No * *During the first check we will provide you additional information regarding this issue.*
Do you currently take folic acid tablets?	Yes/No * *If no: It is recommended you take extra folic acid until the 11th week of your pregnancy. These tablets can be obtained via your apothecary or pharmacy.*
Have you used medicines right before or during this pregnancy?	Yes/No * If yes: Which? In what quantities?
Do you or your partner smoke?	Yes, I do / Yes, my partner does / No / Stopped* If yes: How much do you smoke per day?
Do you use alcohol during pregnancy?	Yes/No * If yes: How much alcohol do you use?
Have you ever used drugs or are you currently using any?	Yes/ No / Used before * If yes: Which drugs are (were) you using? How often?
Are you on a particular diet? (e.g. vegetarian)	Yes/No * If yes: What type of diet?
Do you think you have a healthy eating pattern?	Yes/No * If no: Why not?
Have you had chicken pox yourself? Or have you been in contact with anyone having chicken pox during pregnancy?	I have had chicken pox / no contact / contact * If contact: When was this?
Have you ever been treated by a psychologist or psychiatrist?	Yes/No * If yes: What was the reason? When?
Have you ever had a depression or a burn-out?	Yes/No * If yes: What was your condition? When? How were you treated?
Have you had a blood disease like thalassemia or sickle cell disease? Or does this occur in your family?	Yes/No * If yes: What type of blood disease?
Have you been admitted to a foreign hospital recently?	Yes/No * If yes: Where and when?
Do you suffer from allergies and/or are you allergic to specific medicines?	Yes/No * If yes: To what?

Do you have specific health problems which have not been mentioned above?	Yes/No * If yes: What type?
Have you recently visited a foreign country?	Yes/No * If yes: Where have you been?
Have you been admitted in a foreign hospital in the past 6 months?	Yes/No * If yes: Where and for what?

Family Background:

Does any form of diabetes occur in your close family?	Yes/No * If yes: Who?
Does high blood pressure occur in your close family?	Yes/No * If yes: Who?
Does thrombosis occur in your close family?	Yes/No * If yes: Who?
Are there any members in your close family who have asthma, hay fever or eczema?	Yes/No * If yes: Who?
Are there any congenital disorders in your mutual families? (E.g Down syndrome, spina bifida defect, heart conditions, etc.)	Yes/No * If yes: What type of disorder? Whom does it concern? Do you know whether this disorder is genetic?
Are there any members in your family with psychological problems? (E.g. depression, psychosis, mental disorders, etc.)	Yes/No * If yes: What type of problem? Whom does it concern?
Has any of your grandmothers or mothers had one or more stillborn babies, at a pregnancy duration of more than 4 months?	Yes/No * If yes: Is there a cause known for this?
If you have any children, are they in good health?	Yes/No * If no: What disease(s) do they have?
Is your partner (the father of the baby) healthy?	Yes/No * If no: Why not?
Does your partner have children from a previous relationship?	Yes/No * If yes: Are these children healthy?

Additional Information:

Are there any other issues which you think may be important for us to know?	