2020-07-08

VÄSTRA GÖTALANDSREGIONEN

Health information, pregnancy

Please fill in this form and bring it with you to your appointment. We will go through it together with you, and you can take up any other additional issues at that time. Please, bring your ID.

Personal information

Name:_____

PIN:_____

Address:_____

_____

Phone, home: _____ Phone, work: _____

Mobile phone: _____ Is it OK for the clinic to send text messages to this number written to re-schedule/cancel appointments? □ Yes □ No

Current occupation and workplace or school: _____

Degree of employment (full-time/part-time, %): _____

Employer/address at work:_____

Country of birth:_____

Maternal language:_____

Do you need an interpreter? □ Yes □ No

Partner/next of kin: _____

Relationship (married, cohabiting, partner but living separately, other): _____

Partner´s mobile phone: _____

Partner´s occupation and workplace/school: _____

Social situation

Do you live with your baby´s other parent? _____

Other situation: _____

Problems with work or home environment: _____

Education:

□ None or less than 9 years of school □ Elementary school

□ High school, secondary school □ University

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Lifestyle

Are you physically active? _____If yes, what kind of activity? _____

_____

Food habits: do you keep to any special diet? _____

_____

General

First day of last menstrual period: _____

Interval between first days of your periods: _____

Date of positive pregnancy test: _____

Stopped using contraception, date: _____

Weight: _____

Height:_____

Previous pregnancies and deliveries:

How many years have you tried to become pregnant? _____

Have you had fertility treatment, which? _____

Miscarriages:

Year and month:	Week of pregnancy:	Hospital/clinic:	Treatment, any complications:

Abortions/terminations:

Year and month:	Week of pregnancy:	Hospital/clinic:	Treatment, any complications:

Deliveries:

Year and month:	Week of pregnancy:	Sex:	Birth weight:	Hospital:	Vaginal delivery, cesarean section, ventouse/forceps, any complications	Baby´s current health:

Your physical health

Please indicate if you **have or have had**:

Autoimmune disease (e.g. SLE (lupus), multiple sclerosis, celiac disease, rheumatic disease		Epilepsy	
Asthma or other lung/respiratory disease		Gynecological illness, for instance cervical dysplasia, genital herpes, endometriosis	
Bleeding disorder, for instance hemophilia		Hereditary increased risk of blood clots (thrombophilia)	
Blood clots (thrombosis)		HIV	
Blood disorder (e.g. thalassemia, sickle cell)		Hypertension (high blood pressure)	
Blood transfusion		Jaundice (e.g. hepatitis B or hepatitis C)	
Cancer		Kidney disease	
Cardiovascular disease		Surgery for obesity	
Congenital malformation or hereditary illness		Syphilis	
Crohn's disease or ulcerous colitis		Thyroid disease, for instance Grave´s disease, goiter, thyrotoxicosis	
Diabetes		Tuberculosis	
Ehler-Danlos syndrome		Urinary tract infection, pyelonephritis	

Comments:_____

_____

Allergies:_____

Last Pap (cervical) smear? _____

Have you taken any medications, vitamin supplements or health food products during your pregnancy? If so, which? _____

Are you currently taking any medications? If so, please state name of medication and dose:

_____

_____

Have you been x-rayed or vaccinated during this pregnancy? When? Reason? _____

_____

Have you been vaccinated as part of Sweden´s vaccination program for children? _____

Have you ever had surgery or been admitted to hospital? _____

_____

Have you been in a health care facility (clinic, dentist´s office, hospital) , as a patient or as an employee, **during the last year**?_____

Your mental health

Please indicate if you **have or have had**:

Anxiety/panic		Neuropsychiatric disorder (e.g. ADHD, ADD, autism spectrum disorder)	
Been treated by a psychiatrist (in- or outpatient)		Obsessive-compulsive disorder	
Depression		Self-harm	
Depression or anxiety related to previous pregnancy/delivery		Serious mental illness related to previous pregnancy/delivery	
Eating disorder		Serious mental illness (e.g. psychosis, bipolar disorder, attempted suicide)	

Comments:_____

_____

Self-rated health

How would you rate your health prior to pregnancy?

□ Very good □ Good □ Neither good nor bad

□ Bad □ Very bad

Family history

Do you have any first-degree relatives (parents, siblings, children) who **have or have had** any of the following?

Blood clots (thrombosis)		Hemophilia	
Congenital malformations, hereditary illness		Preeclampsia (toxemia of pregnancy)	
Diabetes type 2		Serious mental illness related to pregnancy/delivery	

Does your expectant child´s father/donor have any hereditary illness? If so, which?

_____