Please fill in the following form:

Full name: _____

Date of birth: _____ **Age**: _____

Adress: _____

Cellphone number: _____

Nationality: _____ **Family status:** _____

Profession: _____

Health insurance: _____

Private insurance: _____ 1 bed _____ 2 beds _____family room

_____

Full name of partner: _____ **Cellphone number:** _____

Relatives: _____ **Cellphone number**: _____

Medical history:

Allergies: _____
Do you need: _____ glasses/lenses _____ hearing aid _____ walking frame

Do you have any diseases?

Diabetes/pregnancy diabetes: _____
Heart disease: _____
Kidney disease: _____
High blood pressure: _____
Tendency to bleed: _____
Thrombosis: _____
Liver disease/hepatitis: _____
Epilepsy: _____
Neuropathy/depression: _____
Spinal disease/slipped disc: _____
Hip displasia: _____
Thyroid disease: _____
Anemia: _____

Do you take any medication regularly, if so, which/how often?

_____
_____
_____

Have you ever received a blood transfusion? _____

Have you ever had an examination for blood clotting disfunction?

_____ no
_____ yes/diagnosis:

Questions regarding your pregnancy:
Due Date: _____
Weight before pregnancy: _____ kg. Height: _____
Sterility therapy (e.g. ICSI, IVF, Insemination etc.): _____

Number of pregnancies: _____
Number of child births: _____
Complications: _____

Alcohol abuse during pregnancy:_____
Nicotine: _____(if so, how many/per day) _____
Drug abuse during pregnancy: _____

Have you ever had surgery?

C-section:_____
Abdominal surgery:_____
Other surgeries:_____
Problems with anesthesia: _____
Conization/Surgery at cervix: _____

Would you like to have a birth planning consultation with a doctor?
_____
_____

Family history:

	Biological father:	Parents/siblings of the pregnant mother:

Diabetes:_____
Epilepsy: _____
Hip disfunction: _____
Neuropathy/depression:_____
Thrombosis: _____
Malformation: _____
Other medical problems: _____