MOTHER´S DETAILS	Surname (include any previous surname(s))		
	Given names		Identity number
	Address		
	Telephone (work, home, mobile)	E-mail address	Mother tongue
	Civil status	Profession	Employer
	Place of birth	Domicile	Parish / civil register
FATHER´S / SPOUSE´S DETAILS	Name		Date of birth
	Address	☐ Address, the same as the client´s	
	Telephone (work, home, mobile)	Profession	
PRELIMINARY INFORMATION	Is this your first pregnancy? ☐ Yes ☐ No	Age	Menstruation ☐ regular ☐ irregular
	Last menstruation, date	Menstrual cycle, days	Last PAP test, date
	Height and weight before the pregnancy cm kg	Prior contraception, which Ended, date:	
	Preceding infertility treatment ☐ Artificial treatment, which? ☐ Other, which?		

PREVIOUS PREGNANCIES AND CHILD-BIRTHS	Year (of last pregnancy, also the date)	Incomplete pregnancy (weeks)	Sex	Alive (a) Dead at birth (db) Dead (d)	Weight at birth (g)	Progress of pregnancy, childbirth and puerperium	Duration of pregnancy (weeks)	Duration of childbirth (hours)	Duration of breast-feeding (months)	Place of birth

HEALTH HABITS **M = mother** **F = father / spouse**	**Before pregnancy**			**During pregnancy**			Physical exercise/sports
	Smoking	Alcohol	Drug use / experimen-tation	Smoking	Alcohol	Drug use / experimen-tation	
	M / F ☐☐ No ☐☐ Yes Quantity/ day:	M / F ☐☐ No ☐☐ Yes Quantity/ week:	M / F ☐☐ No ☐☐ Yes	M / F ☐☐ No ☐☐ Yes Quantity/ day:	M / F ☐☐ No ☐☐ Yes Quantity/ week:	M / F ☐☐ No ☐☐ Yes	
	Are you daily exposed to tobacco smoke? ☐ No ☐ Yes			Are you daily exposed to tobacco smoke? ☐ No ☐ Yes			
NUTRITION DIET	☐ Normal ☐ Special diet, what?						

SIGNIFICANT ILLNESSES
M = mother,
F = father

M / F	M / F	M	M (Illnesses of childbearing organs)
☐ ☐ Diabetes	☐ ☐ Epilepsy	☐ Urinary tract infection	☐ Operations
☐ ☐ Arterial hypertension	☐ ☐ Neurological illnesses	☐ Thyroiditis	☐ Tumours
☐ ☐ Allergy	☐ ☐ Psychological illnesses	☐ Rheumatism	☐ Hormone therapy
☐ ☐ Renal disease	☐ ☐ Congenital malformation	☐ Operations	☐ Sexually transmitted disease
☐ ☐ Heart disease	☐ ☐ Disability/sensory defect	☐ Chickenpox	☐ Other, what?
☐ ☐ Liver disease	☐ ☐ Herpes genitalis	☐ German measles	
☐ ☐ Lung disease	☐ ☐ Hepatitis	☐ Blood transfusion	
☐ ☐ Other, what?	☐ ☐ HIV		

Additional information about mother´s illnesses and places of treatment

Medication

Significant illnesses of near relatives

Does the father want to take part in clinic visits during pregnancy, in parent training and in confinement?

What do you expect from maternity clinic visits?

How do you feel about your pregnancy at the moment?

SIGNATURE

Date Signature

For reasons of data security, do not send the form by e-mail. Please fill in the form and bring it with you on your first visit in the maternity and child health centre.