ukb universitäts klinikumbonn

Abteilung für Geburtshilfe und Pränatale Medizin
Universitätsklinikum Bonn
Venusberg Campus 1
53127 Bonn

Frau Prof. B. Strizek – Geburtshilfe und Pränatale Medizin
Zentrum für Geburtshilfe und Frauenheilkunde, UKB,

Tel. 0228 – 287 37100 / Fax. – 37131
termine.praenatal@ukbonn.de

Medical history form

Personal Data

Surname: ____________________________ First Name: ___________________________

Date of Birth: ________________________ Profession: ____________________________

Adress: ____

Phone number: ____________________ Mobil number: ____________________________

E-Mail: ___________________________________

Emergency Contact

Surname: ____________________________ First Name: ___________________________

Adress: ____

Phone number: ____________________ Mobil number: ____________________________

Medical history /personal data

Height: ___________

Weight before Pregnancy: _______________ (kg) current weight: _______________ (kg)

Do you smoke: Yes ☐ No ☐ If yes, how many cigarettes a day: ___________

Do you drink alcohol: Yes ☐ No ☐ If yes, how much a day: _________

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Do you take medication on a regular basis? Yes ☐ No ☐

If yes, which: ____

____

____

____

Do you have any pre-existing conditions?

Diabetes mellitus type 1 yes ☐ no ☐ since when ____________

Diabetes mellitus type 2 yes ☐ no ☐ since when ____________

Heart disease yes ☐ no ☐ since when ____________

Thyroid disease yes ☐ no ☐ since when ____________

Hypertension yes ☐ no ☐ since when ____________

Others ____

Allergies ____

Pregnancy data

First day of the last menstrual period ____________________

Estimated date of Delivery ______________

Mode of Conception ☐ spontaneous ☐ IVF ☐ ICSI ☐ other

Egg collection date: ______________ Embryo transfer date: ____________

Number of embryos inserted ______________

Do you want to know the sex of the Baby? Yes ☐ No ☐

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Pregnancy Course

Have you had any problems during this pregnancy, e.g. bleeding, hyperemesis, contractions?

If yes, please specify ____

Did you have any previous examinations/interventions in this pregnancy? (E.g. Amniocentesis or chorionic villous sampling?)

Yes ☐ no ☐

If yes which one: _______________________________ Where: ___________________________

When: _______________________________________ Result: ____________________________

Obstetrical history

Number of pregnancy's ___________________ Number of births _________________________

Number of miscarriages __________________ Number of extra uterine pregnancy's _____________

Number of Termination of pregnancy _________________

Date of birth	Weight	Gender	Week of pregnancy	Way of delivery	Complications

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Did you have major gynecological operations, like laparoscopy, myomectomy...?

Yes ☐ No ☐

If yes, which and when: ____

Are there any chromosomal defects or genetic disorders in your family?

Yes ☐ No ☐

If yes, who and what condition: ____

Are there any malformations in your family, e.g. heart defects, spina bifida or renal malformations?

Yes ☐ no ☐

If yes, please specify ____

Which doctors should receive a report?

☐ Gynecologist ____

☐ Others ____

____

____

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Name ____________________________ Date of Birth: _____________________

Dear Miss ______________________

- You were send to us for an ultrasound examination. Your doctor will receive a report and also other results that might follow, e.g. blood test results, Karyotype

  Do you agree with this? Yes ☐ no ☐

- Do you agree that we can obtain reports about you and your birth or rather about your child from extern hospitals or doctors? Yes ☐ no ☐
- I agree that my medical information's can be used anonymously for research purpose.

  Yes ☐ no ☐

- According to German law "Gendiagnostikgesetz" you can decide how long results of examinations used to be stored.
  - I want all results to be stored *longer* than 10 years.

    Or

  - I want all results to be destroyed *after* 10 years.

Bonn, _____________________ ___________________________________

Signature