Obstetric History Questionnaire

Fam. name __________________________ Name: __________________________

Day of birth: ______________________ Phone number: __________________________

Questions to this pregnancy:
Did you have any fertility treatment? □ yes □ no
If yes □ Hormon stimulation □ Insemination □ IVF □ ICSI

Were there/are there any problems with your current pregnancy? If yes, please describe them below?

Where were ultrasound examinations done till now?

Did you do any prenatal genetic test?

☐ Amniocentesis ☐ Chorionbiopsie ☐ NIPT-Test

Prior pregnancies (deliveries, miscarriages, abortion, etc.):

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<thead>
<tr>
<th>Year</th>
<th>Sex</th>
<th>Weeks</th>
<th>Type of delivery</th>
<th>Birth Weight</th>
<th>Complications during the pregnancy</th>
<th>Complications during labor and delivery</th>
<th>Child healthy?</th>
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Questions about the medical history:
Do you smoke? Do you consume alcohol? Have you used any drugs?
□ yes □ no □ yes □ no □ yes □ no

Do you have any known allergies? If so, please list them below.

Do you have any medical conditions? If so, please list them below.

Have you ever undergone surgery? If so, please give brief details.

Do you currently take any medication? If so, please list them below.

Are there any inherited genetic or chromosomal disorder run in your family or in the family of your partner?

Social anamnesis:
What is your occupation?