diakoneo
KLINIK HALLERWIESE
Abteilung Geburtshilfe und Pränatalmedizin

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 (delieveries, miscarriages, abortion, etc.):

Year	Sex	Weeks	Type of delievery	Birth Weight	Complications during the pregancy	Complications during labor and delivery	Child healthy?

Questions about the medical history:

Do you smoke? ☐ yes ☐ no

Do you consume alcohol? ☐ yes ☐ no

Have you used any drugs? ☐ 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? _____