Närhälsan

Questionnaire for medical record

Please fill in this form and bring it at your next visit, as a basis for your medical record. We will go through the questionnaire with you, so you will be able to make any necessary corrections at that time. Please, bring your ID as well!

Personal information

Name:_____

PIN:_____

Address:_____

_____

Phone, home:_____

Phone, work:_____

Mobile phone:_____

Profession:_____

Full- or part-time employment:_____

Employer/address at work:_____

Partner/next of kin:_____

Marital/relationship status:_____

Phone, work:_____

Mobile phone:_____

Profession:_____

Employer/address at work:_____

Education:

□ None or less than 9 years

□ Elementary school (9 years)

□ Secondary school (12 years)

□ University

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General information

Country of birth:_____

Native language:_____

First day of last menstruation:_____

Interval between menstruations:_____

Duration of menstruation:_____

Pregnancy test positive (date):_____

Stopped taking birth control pills (date):_____

IUD removed (date):_____

Current weight:_____

Height:_____

Social situation

Cohabiting with your baby´s father/mother:_____

Other situation:_____

Problems with work and/or home environment:_____

Exercise:_____Type of exercise:_____

Diet (vegetarian, vegan, other):_____

Previous pregnancies and births:

Long-term attempt to conceive:_____

Assisted reproduction:_____

If yes, method (IVF, oocyte donation, other):_____

Miscarriage:

Year and month:	Pregnancy week:	Hospital:	Treatment complications:

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Abortions:

Year and month:	Pregnancy week:	Hospital:	Method, complications:

Deliveries:

Year and month:	Pregnancy week:	Gender:	Birth weight:	Hospital:	Method of delivery, complications:	Child´s current health:

Medical history

Please mark any of the following that you have or have had previously:

Cardiovascular disease		Thrombosis (blood clots)	
Obesity surgery		Jaundice (hepatitis)	
Gynecologic illness, including abnormal Pap smear		Endocrine disorder, such as thyroid disorder	
Urinary tract infection, including pyelonephritis		Asthma or other lung disease	
Kidney disease		Inflammatory bowel disease, such as Crohn's disease or ulcerative colitis	
Diabetes		Arthritis or other joint disease	
Epilepsy		High blood pressure	
Increased bleeding tendency		Autoimmune disease, such as SLE, MS, celiac disease, pernicious anemia	
Blood disorder, such as thalassemia		Contagious disease, such as hepatitis	

Comments:_____

_____

Allergy:_____

When was you're your last Pap smear?_____

Have you taken any medications or alternative medicine since you became pregnant? If yes,

which/what?:_____

Are you taking any medications now?_____

_____

Have you been x-rayed or vaccinated since you became pregnant?_____

If yes, when and for what?_____

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Have you ever had surgery or been hospitalized?_____

_____

Have you ever had a blood transfusion?_____

Have you been hospitalized, or had a medical or dental procedure, abroad during the last year?_____

Psychiatric history

Please mark any of the following that you have or have had previously:

Serious psychiatric illness, such as psychosis, bipolar disorder, attempted suicide		Been an outpatient or inpatient at a psychiatric clinic	
Depression		Anxiety/panic attacks	
Self-harming		Eating disorder	
Obsessive-compulsive disorder		Neuropsychiatric disorder (ADHD, ADD, autism spectrum)	
Serious psychatric disorder, related to previous pregnancy or delivery		Depression or anxiety, related to previous pregnancy or delivery	

Comments:_____

_____

Family history

Do any of your immediate family (parents, siblings, children) have any of the following?

High blood pressure		Hemophilia	
Diabetes		Thrombosis (blood clots)	
Serious psychiatric illness related to pregnancy or delivery		Autoimmune disease, such as SLE, MS, celiac disease, pernicious anemia	
Endocrine disorder		Malformations, genetic disorders	
Preeclampsia		Other	

Have you been given information on:

The Biobanks in Medical Care Act?_____

Our computerized medical records?_____

Self-reported health

How would you describe your health before pregnancy?

□ Very good □ Good □ Neither good nor bad

□ Relatively poor □ Poor