Barnmorskemottagningar, Regionhälsan
2024-01-26

Health information, pregnancy

Please fill in this form and bring it with you to your appointment. We will go through it together with you, and you can take up any other additional issues at that time. Please bring your ID.

Personal information

Name:

Swedish Personal identity numbers and coordination numbers:

Address:

Phone number:

Is it OK for the clinic to send text messages to this number to re-schedule/cancel appointments? ☐ Yes ☐ No

Is it OK for the clinic to send text messages by 1177/e-services? ☐ Yes ☐ No

Current occupation and workplace or school:

Degree of employment (full-time/part-time,%):

Problems/hazards in work environment:

Do you need an interpreter? ☐ Yes ☐ No

Partner/next of kin:

Relationship (married, cohabiting, partner but living separately, other):

Partner´s mobile phone:

Partner´s occupation and workplace/school:

Social situation

Do you live with your baby´s other parent?

Other situation:

Problems with home environment:

Lifestyle

Are you physically active? ☐ Yes ☐ No If yes, what kind of activity?

Dietary habits: do you keep to any special diet?

General

First day of last menstrual period:

Interval between first days of your periods:

Date of positive pregnancy test:

Stopped using contraception - date:

Current weight:

Height:

Previous pregnancies and deliveries

How many years have you tried to become pregnant?

Have you undergone fertility treatment? If yes, which one?

Miscarriages

Year and month	Week of pregnancy	Hospital/clinic	Treatment, any complications

Abortions/terminations

Year and month	Week of pregnancy	Hospital/clinic	Treatment, any complications

Deliveries

Year and month	Week of pregnancy	Hospital/clinic	Treatment, any complications

Your physical health

Please indicate if you have or have had:

☐	Autoimmune disease, e.g. SLE (lupus), multiple sclerosis, celiac disease, rheumatic disease	☐	Hereditary increased risk of blood clots (thrombophilia)
☐	Asthma or other lung/respiratory disease	☐	HIV
☐	Bleeding disorder, e.g. hemophilia	☐	Hypertension (high blood pressure)
☐	Blood clots (thrombosis)	☐	Jaundice, e.g. hepatitis B or hepatitis C
☐	Blood disorder, e.g. thalassemia, sickle cell disease	☐	Kidney disease
☐	Cancer	☐	Malignant hyperthermia
☐	Cardiovascular disease	☐	Porphyria
☐	Congenital malformation or hereditary illness	☐	Surgery for obesity
☐	Crohn’s disease or ulcerous colitis	☐	Syphilis
☐	Diabetes	☐	Thyroid disease, e.g. Grave´s disease, goiter, thyrotoxicosis
☐	Ehlers-Danlos syndrome	☐	Tuberculosis
☐	Epilepsy	☐	Urinary tract infection, pyelonephritis
☐	Gynecological illness, e.g. cervical dysplasia, genital herpes, endometriosis	☐	Other:

Comments:

Allergies:

Last Pap (cervical) smear or self-test for HPV?

Have you taken any medications, vitamin supplements or health food products during your pregnancy? If yes, which ones:	☐ Yes	☐ No
Are you currently taking any medications? If so, please state the name of medication and dose:	☐ Yes	☐ No
Have you been x-rayed or vaccinated during this pregnancy? If yes, when? Reason?	☐ Yes	☐ No
Have you ever had a blood transfusion? If yes, when was it? Year, month and date:	☐ Yes	☐ No
Have you completed Swedish vaccination programme for children?	☐ Yes	☐ No
Have you ever had a surgery or been admitted to hospital?	☐ Yes	☐ No
Have you been a patient or employee in a health care facility abroad (clinic, dentist´s office, hospital) **during the last year?**	☐ Yes	☐ No

Your mental health

Please indicate if you have or have had:

☐ Depression/Postpartum depression	☐ Eating disorder
☐ Anxiety	☐ Neuropsychiatric disorder, e.g. ADHD, ADD, autism spectrum disorder.
☐ Self-harm	☐ Been a patient (in- or outpatient) in a psychiatric unit.

Comments:

Family history

Do you have any first-degree relatives (parents, siblings, children) who have or have had any of the following?

☐	Serious mental illness related to pregnancy/delivery	☐	Malignant hyperthermia
☐	Bipolar disorder	☐	Congenital malformations, hereditary illness
☐	Blood clots (thrombosis)	☐	Preeclampsia (toxemia of pregnancy)
☐	Blood disorder, e.g. hemophilia, thalassemia	☐	Type 2 diabetes
☐	Other:		

Baby's father or donor

Does your baby's father/donor have or has he had any of the following?

☐	Blood or bleeding disorder, e.g. hemophilia, thalassemia	☐	Congenital malformations, hereditary illness
☐	Cardiovascular disease, heart malformation, heart surgery or other heart treatment	☐	Malignant hyperthermia
☐	Other:		

Additional information

Do you consent that your samples stores in Biobanken
For more information: E1 Change of consent (biobanksverige.se) ☐ Yes ☐ No

Graviditetsregistret

Questions for the Swedish Pregnancy Register, a national quality register

You´ll find more information here:
The Swedish Pregnancy Register | Graviditetsregistret (medscinet.com)

Do you consent to participate in the The Swedish Pregnancy Register?	☐ Yes	☐ No

Country of birth:

Educational level:	☐ Did not attend school or less than nine years of school ☐ Elementary school (1–9 years) ☐ Secondary school (10–12 years) ☐ University or post-secondary
Occupation:	☐ Working ☐ Student ☐ Parental-leave ☐ Unemployed ☐ Sick-leave ☐ Other
Self-assessed health before pregnancy:	☐ Very good ☐ Good ☐ Neither bad or good ☐ Bad ☐ Very bad