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**We kindly ask you to fill in this client information form, and send it back by mail or post, before the first appointment with the midwife**.

(If you don’t speak Dutch or English please take a translator with you to the appointment)

**Information Client:**

First name:

Last name:

Date of birth:

Nationality:

Native language:

Do you speak Dutch or English:

Address:

Zip code:

City:

Home Phone:

Cell Phone:

E-mail address:

Are you married: Yes / No

Profession/ Occupation Fulltime/part-time\*

Religion:

Family physician:

Insurance company:

Insurance number:

Social security number/BSN:

How did you find us?:

**Information partner of client:**

First name:

Last name:

Date of birth:

Cell Phone:

Profession/ Occupation: Fulltime/part-time\*

**Prior pregnancies:**

Is this your first pregnancy? Yes / No \*

If it’s not your first pregnancy, fill in:

How many times have you given birth:

How many children do you have:

Have you had miscarriage(s):

Have you had an abortion:

*(if you have medical records and information, please take them with you to the appointment)*

**Current pregnancy:**

Is it a planned pregnancy? Yes / No \*

How many months did it take to get pregnant? ….... months

**Menstrual cycle:**

What was the first day of your last menstruation? Date: ……/……/…….

Was the last menstruation normal? Yes / No \* If not, describe:

Did you always have a regular menstruation cycle? Yes / No \*

How many days was your cycle? <26 days / 28-33 days / >33days

Did you use contraception before this pregnancy? Yes / No \*

If you did, what kind?:…………………….

When did you stop using the contraception?: …../……/20…

When was the first time you had a positive pregnancy test? …… - …… - 20……

Did you already have an ultrasound? Yes / No \*

*(if you have medical records of the ultrasound, please take them with you to the appointment)*

**Medical information:**

What is your height? ……………… cm.

What was your weight before the pregnancy? ……………… kg.

Have you ever had a bladder infection? Yes / No \*

If so, how many times?:……

When was the last time?:…….

Have you ever had a severe dental infection? Yes / No \*

…………………………………………….

Have you ever had a vaginal (fungal) infection/ candida infection? Yes / No \*

If so, how many times?:……

When was the last time?:…….

Have you ever had a cervical smear test for cervical cancer? Yes / No \*

What was the outcome of the smear test?................

Have you had chickenpox/ varicella as a child? Yes / No \*

Do you or your partner ever have a cold sore? No / Yes I do / yes my partner does

Have you’ve been admitted to a foreign hospital in the last 6 months? Yes / No \*

Have you ever had a blood transfusion? Yes / No \*

If so, what was the reason for getting a blood transfusion?...............

Have you ever had thrombosis (in your legs)? Or thrombosis in the longs? Yes / No \*

If so, when was it?:…………….

How what the thrombosis treated?.........

Do you use folic acid? Yes / No \*

When did you start using folic acid?:………..

Did you use medication before the pregnancy? Yes / No \*

If so, what kind of medication?...............................

How much medication do you use daily?.......................

Do you have a medical condition for which you have to visit the general practitioner on a regular basis?

Yes / No \*

If so, what kind of condition do you have?................................................

Have you ever had an operation/surgery? Yes / No \*

If so, what kind of operation/surgery was it? When was it? Were there any complications?...................................

*(if you have medical records and information, please take them with you to the appointment)*

Have you ever had a negative sexual experience?

Or encountered domestic violence or verbal abuse?

Or other kinds of violence or abuse? Yes / No \*

If so, then we will discuss this in private during the first appointment.

Have you ever received treatment form a psychologist? Yes / No \*

If so what was the reason?

When did you receive treatment?

Do you have a medical condition for which you have to visit a specialist in the hospital on a regular basis?

Yes / No \*

If so, what kind of condition do you have?...........................

Have you ever had an STD (sexual transmitted disease)? Yes / No \*

If so, what kind of STD was it? when was it? How did it get treated?

…………………………………………..

Are you allergic to anything? Yes / No \*

If so, what are you allergic to?

…………………………………………

What kind of allergic reaction do you get?...................................................

Do you smoke cigarettes? Yes/No/I stopped smoking

Does your partner smoke cigarettes? Yes/No/my partner stopped smoking

If you smoke: how much do you smoke?.......................................

Did you drink alcohol before the pregnancy? Yes/ No

If you did, how much did you drink per week?...................................................

Do you drink alcohol now you know that you’re pregnant? Yes/ No

Have you ever used drugs? Yes/ No

If so, what kind of drugs? And when was the last time you used drugs?.........................................

Are you now using any kind of drugs? Yes/ No

If so, how much do you use?..........

Do you have or use a special diet? Yes/ No

(for example vegetarian..) If so, what kind of diet?...................

Do you have healthy diet and lifestyle? Yes/ No

If you don’t, can you explain why not?................................

Have you ever had extra help from youth care or/and child protection care? Yes/ No

If so, when and why?

…………………………………………..

Have you ever had financial problems? Have you ever attended a debt restructuring program? Have you ever been in contact with financial support agencies?

Yes / No  
If so, can you tell us when an why?..................................

**Familial medical history:**

If you have a child/ children, are they healthy? Yes/ No

……………………………………

Is your partner or the father of the baby healthy? Yes/ No

……………………………………

Does your partner have children from a prior relationship? Yes/ No

……………………………………

Are there any congenital malformations or diseases in your family of your partners family?

(for example down syndrome, a harelip or hart disease?)

Yes/ No

If so, can you tell us more about it? ………………………………

……………………………………

Were there any stillborn baby’s in the family? Yes/ No

…………………………………….

Are there any family members with psychological problems or disorders? Yes/ No

…………………………………….

Are there any family members with asthma, hay fever or eczema? Yes/ No

…………………………………….

Do you or any close family members have diabetes? Yes / No

Which family member has diabetes?.....

…………………………………………….

Do you or any close family members have high blood pressure? Yes/ No

Which family member has high blood pressure?...............................................

Do you or any close family members have tuberculosis? Yes/ No

Which family member has tuberculosis?.........................................

Do you or any close family members have thyroid disease/ deficiency? Yes/ No

Which family member has thyroid disease/ deficiency?..............................

Do you have other (medical) problems that we didn't mention in this file? Yes/ No

……………………………………………………………………………………………………

…………………………………………………………………………………………………….

**Thank you for filling in this form.**