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Dear client,

To be able to provide you with the best care possible, we would like to know more about your personal situation. Below you find some questions concerning your medical and social background. We kindly ask you to fill in this form and email it to [info@verloskundigenhetooievaarsnest.nl](mailto:info@verloskundigenhetooievaarsnest.nl) before your first appointment. The midwife will discuss it with you and your partner. If there are any particularities, they can be discussed in detail during your first appointment. Thank you in advance!

The team of Het Ooievaarsnest

(If you don’t speak Dutch or English please bring a translator with you to all of your appointments)

**Personal information client**

*\*score out what does not apply*

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:

Marital status:

Profession/ Occupation: Fulltime/part-time\*

Religion:

Family physician:

Insurance company:

Insurance number:

Social security number/BSN:

**Personal information partner**

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 you have given birth?................................

How many children you have?..............................................

How many miscarriage(s) you had?.....................................

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 period? Date: ……/……/…….

Was your last period normal? Yes / No\* If not, please describe:

Have you always had a regular menstruation cycle? Yes / No\*

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

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

If you did, what kind?…………………….

When did you stop using birth control? …../……/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\*

If so, what was the outcome of the test?................

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

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

Have you 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?...............

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

Or thrombosis in the longs? Yes / No\*

If so, when was it?:…………….

How was it treated?.........

Do you use folic acid? Yes / No\*

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

Did you use any 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 surgery? Yes / No\*

If so, what kind of 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,

encountered domestic violence, verbal abuse or

other kinds of violence? Yes / No\*

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

Have you ever received treatment from 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 since….

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

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

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/ I used to\*

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

Have you ever used drugs? Yes/ No\*

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

Are you using any kind of drugs now? 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, attended

a debt restructuring program or been in contact

with financial support agencies? Yes / No\*  
If so, can you tell us when and why?..................................

**Familial medical history**

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

If not, what condition do they have?....

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

If not, please explain….

Does your partner have any children from a prior

relationship? Yes/ No\*

If so, are they healthy?........

Are there any congenital malformations or diseases

in your family or 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/ Don’t know\*

If so, is there any known cause?.......

Are there any family members with psychological

problems or disorders? Yes/ No\*

If so, who?........

What is the treatment?......................

Are there any family members with asthma,

hay fever or eczema? Yes/ No\*

If so, who?.......................................

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

If so, who?........................................

Do you or any close family members have

high blood pressure? Yes/ No\*

If so, who?.......................

Do you or any close family members have

tuberculosis? Yes/ No\*

If so, who?.........................................

Do you or any close family members have

thyroid disease/ deficiency? Yes/ No\*

If so, who?..............................

Do you have any other (medical) problems that weren’t mentioned, but which you think are important for us to know? Yes/ No\*

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

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

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