



1 Patient

Name		Title	
First name(s)		Date of birth	
Job			
Street and House number			
Postcode	City		
Telephone number			
Email			
Obstetrician			

2 Current Pregnancy

First day of last period	Estimated due date	Length	Weight
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Is this a twin pregnancy? yes no if yes → single egg two eggs

3 Previous Pregnancies

What no. pregnancy is this one? How many children do you have?

In what years and in what week of pregnancy did you give birth?

Year	Week	Year	Week	Year	Week
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Information about preeclampsia screening

(Complete only as part of pre-eclampsia screening.)

Do you smoke? yes no

Do you have diabetes? yes no

Do you have high blood pressure? yes no

Do you suffer from lupus? yes no

Do you have anti-phospholipid syndrome? yes no

Did you have pre-eclampsia in previous pregnancies? yes no

Did your babies have growth difficulties in your previous pregnancies? yes no

Did your mother have pre-eclampsia? yes no

Did you become pregnant spontaneously? yes no

Did you become pregnant by artificial insemination? yes no

if yes → IVF ICSI

When were the eggs removed? Date

Were your own eggs used? yes no

