Pränatalzentrum
A.D. WIEN

Master data sheet

1 Patient

Name | Title

First name(s) | Date of birth

Job

Address

Street and House number

Postcode | City

Contact details

Telephone number

Email

Obstetrician

2 Current Pregnancy

First day of last period | Estimated due date | Length | Weight

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

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

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