**Form First Appointment**

This form contains questions regarding include your medical history, your menstrual cycle and the medical history of your family. During the first pregnancy, the midwife will check this with you through, so that a complete picture can be drawn of your situation.

It's nice when you fill in this form and mailed back to **verloskundigcentrum@planet.nl** before You arrive at intake. If you do not find this fine, you may of course also print and bring it to your appointment.

**Personal data:**

|  |  |
| --- | --- |
| Data woman  Data Man  Adress  Insurance | Birthdate:  First Name:  Initials:  Family name:  Country of origin:  Place of Birth:  Mobile phone:  E-mail:  Marital status:  religion:  Ethnicity:  Speaks Dutch: Yes / No  Other spoken language:  Birthdate:  First Name:  Initials:  Family name:  Country of origin:  Mobile phone:  Street / number:  Zipcode city:  country:  BSN number  Name of health insurance:  Policy number:  Name/adress family doctor: |

**Menstrual cycle:**

|  |  |
| --- | --- |
| What was the first day of your last menstrual period? | ……. - ……….- 20……. |
| Went this period normal?  If no: Why menstruation was different than usual? | Yes/no |
| Did you have a regular cycle?  If yes: How many days your cycle usually counted? | Yes/no |
| You know the date of conception?  Is this a planned pregnancy?  Took it a long time before the child wish is fulfilled?  Do you use contraception before? | Yes/no  Date?  Yes/no  ………….. months  Yes/ no  If yes what date?  When do you stop this?……. - ……….- 20……. |
| When did your pregnant-shelf test for the first time a positive result? | ……. - ……….- 20……. |

|  |  |
| --- | --- |
| Have you already had an ultrasound? | Yes/no  *If yes: Please note the results.* |

**Herkomst:**

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| --- | --- |
| How did you know of the Obstetric Center ‘Verloskundig Centrum” ? | (Multiple answers possible.)   My doctor has referred me.   My gynecologist referred me.   through the phone book.   With friends/family around me.   internet.   From my previous pregnancy   Other, namely: |
| Why did you choose the Obstetric Center “verloskundig centrum” ? | (multiple answers possible)  0 Clear website  0 Possibility evening / Saturday office hours  0 Echo present  0 Satisfaction family / friends  0 Recommended by family doctor / gynecologist        0 Other: |

|  |  |
| --- | --- |
| Have you been managing this pregnancy a gynecologist? | Yes/no  Who? |
| What is your height? | .......... (cm) |
| What is your weight at the beginning of pregnancy. | ………….. (kg) |

**Zwangerschapsverleden:**

|  |  |
| --- | --- |
| Is this your first pregnancy?  Is this your partner first pregnancy? | Yes/ No \*  If no:  Number of Pregnancies:  Number of births:  Number of miscarriages:  Number of abortions:  Have you ever had an ectopic pregnancy? Yes/ No  Yes/no  If possible data from your previous pregnancies) and birth (s) back to the first check |

**Social Data:**

|  |  |
| --- | --- |
| Do you have a job?  What is your function? | Yes/no |
| Is your partner working?  What is his function? | Yes/No |

**Medical History:**

|  |  |
| --- | --- |
| *Had you ever had a bladder infection?* | *Yes/ No*  *If yes: How often have you had this in the past? When exactly?* |
| *Do you ever suffer from bleeding gums or nose haemorrhage?* | *Yes/no* |
| *Have you ever had a vaginal yeast infection?* | *Yes/ No*  *If yes: How often have you had this in the past? When exactly?* |
| *Have you ever had a cervical smear?* | *Yes No \**  *If Yes: When was this (year) and that PAP was it?* |
| *Have you ever had chickenpox?* | *Yes/no* |
| *Have you ever had a cold sore?* | *Yes/no* |
| Have you recently located in a foreign hospital (because MRSA) or are you regularly in contact with a pig? | *Yes/no*  *If yes: When and for what reason?* |
| *Have you ever had a blood transfusion?* | *Yes/no*  *If yes: What was the reason? When?* |
| *Have you ever( thrombosis) or had a pulmonary embolism?* | *Yes/no*  *If yes: When? How were you treated?* |
| *Swallows you currently folic acid tablets?*  *Swallowed you Folate prior to pregnancy, or as soon as you know you are pregnant?* | *Yes No \**  *If yes: I started with folate:*  *Prior to pregnancy / after a positive pregnancy test.*  *If no: It is advised to take extra folic acid to the 11th week of pregnancy. These tablets are available from pharmacies and drugstores.* |
| *Are you healthy?* | *Yes/no* |
| *Did you use drugs, just before or during this pregnancy?* | *Yes/no*  *If yes: Which? In what quantities?* |
| *Have you ever been seriously ill? or something that you should regularly visit the doctor?* | *Yes/No*  *If yes: Could you explain this further?* |
| *Have you ever had surgery?* | *Yes/no*  *If so, what do you have surgery? When?* |
| *Have you ever experienced something gratifying in sexual matters or have you ever had to deal with sexual or domestic violence?* | *Yes/no*  *If yes: During the first control we will talk with you how this will affect you for the experience of pregnancy and childbirth.* |
| *Is there case of circumcision (possibly in conjunction with your relition)?* | *Yes/no* |
| *Have you ever been treated by a psychologist or psychiatrist?* | *Yes No*  *If yes: What was the reason? When?* |
| *Do you have a history with pregnancy / childbirth and was something special about that?* | *Yes/no*  *Explanation:* |
| *Have you ever had a seksual disease?* | *Yes No*  *If so, what and when?*  *Is this treated?* |
| *Are you allergic to anything?*  *Which reaction is to be expected when you are in contact with it?* | *Yes No*  *If yes: what?*  *namely:* |

|  |  |
| --- | --- |
| *Have you ever smoked or currently smoked?*  *Are you aware of the effects of smoking in pregnancy?* | *Yes No*  *Indicate:*  *- Used to smoke*  *- Stopped for current pregnancy*  *- Stopped in the first months of pregnancy*  *- Stopped later in pregnancy*  *- Usually less than 10 per day sig*  *- Smokes an average of 10-20 per day sig*  *- Smokes more than 20 sig per day*  *Yes /No* |
| *Have you ever used drugs or use currently?* | *Yes / No*  *Previously widely used*  *If yes: Which drugs? How often?* |
| *Did you use outside pregnancy alcohol?* | *Yes No \**  *If yes: How much alcohol did you use?*  *Indicate:*  *- no*  *- sporadic*  *- Regularly, 0-2 units per day*  *- A regular basis, two or more units per day* |
| *If you use alcohol in pregnancy?*  *(from the moment you know you're pregnant?)* | *Yes No \**  *If yes: How much alcohol do you use?*  *Indicate:*  *- no*  *- sporadic*  *- Regularly, 0-2 units per day*  *- A regular basis, two or more units per day* |
| *Are you aware of the effects of alcohol during pregnancy?* | *Yes/No* |

**Health partner:**

|  |  |
| --- | --- |
| *Is your partner (the father of your baby) healthy?* | *Yes No*  *If no: Why not?* |
| Will there congenital malformations in the family of the father of the baby? (Think of syndrome v. Down, spina bifida, heart defects, etc.) | Yes No \*  If yes: Which disease? Who? You know if this defect is hereditary? |
| *Has your partner ever cold sores?* | *Yes/no* |
| *Do you havea certain health problem that are not mentioned above?* | *Yes/no*  *Which?* |

**Health Woman:**

|  |  |
| --- | --- |
| Did you as a child to go through thea vaccination program? | Yes/no |
| You authorize us to share information about you and your pregnancy with your partner? | *Yes/no* |
| Will there congenital malformations in the family of the baby's mother? (Think of syndrome v. Down, spina bifida, heart defects, etc.) | Yes No \*  If yes: Which disease? Who? You know if this defect is hereditary? |
| Do you know what you should or should not eat during pregnancy?  Are you aware of the National advised to take multivitamins during pregnancy? | Yes/no  Yes/no |

**Familie achtergrond:**

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| --- | --- |
| Do you suffering from diabetes before, or had in a previous pregnancy?  Is there in your immediate family diabetes?  (father, mother, brothers or sisters) | Yes/no  Yes/no  Who? |
| Is there in your immediate family high blood pressure? | Yes/no  Who? |
| Is there thyroid problem with you? | Yes/no |
| Are there certain health issues that are not mentioned above, but for us important to know? | Yes/no  Which? |
| In the Netherlands, all pregnant data collected in a national database. This allows us to learn from each pregnancy and improve care in the Netherlands. Do you find it good that you go data to the national database? | Yes/no |

As a pregnant woman in the Netherlands you have the opportunity to scan your unborn child. During the First appointment we discuss the possibilityof prenatal screening with you. Before the intake it is nice if you read a bit more information.

Prenatal screening is a choice. It is not a mandatory part of health care.

This can be done via our website www.verloskundigcentrum.nl under the theme of pregnancy and then under the heading 'prenatal screening.You can translate it by google translate with a click on the right of the corner from our webpage. There is also information available at [www.prenatalescreening.nl](http://www.prenatalescreening.nl)

http://www.rivm.nl/dsresource?objectid=rivmp:51018&type=org&disposition=inline&ns\_nc=1

**This form below you don’t have to fill out, just reading please**

**This is offered at the first check for signature.**



Verloskundig Centrum, Graaf Hendrik III laan 63, 4891 CA Breda, tel: 076-5657177

**Consent Form**

The undersigned here by declares, Ms. ................................. born .. / .. / .... , Agreeing to transmit her data about the provided midwifery care to the following organizations: Netherlands Perinatal Registry, Praeventis and Peridos.

**Peridos**

Peridos is a digital file which caregivers in the context of screening for Down syndrome and the 20 week ultrasound data capture to improve the quality and the process of screening and optimizing

**Praeventis**

Data from blood test are recorded in a national registry. This is done to ensure the quality of the blood test and to monitor the process. Praeventis emits a signal such as a result is different and no action is taken.

**PRN**

The aim is to improve the quality of care. The PRN collects data from the entire process by the different disciplines (obstetricians and gynecologists) back and publishes.

Also, I authorize the staff of the Verloskundig Centrum practice obstetrics permission to discuss her health situation with other health professionals and possibly end to arrange a consultation at the hospital of your choice if given the course of the pregnancy, delivery and / or after delivery is necessary in order to provide optimal obstetric care.

Further, the undersigned hereby authorizes the employees of theverloskundig centrum to the medical file or relevant parts there of, available to other relevant responders if necessary to provide optimal obstetric care.

Name: …………………………………………………………………………………………………………………………………………………

Birthdate: …………………………………………………………………………………………………………………………………

Date of signature: …………………………………………………………………………………………………………………

Signature: