

PREGNANCY JOURNAL

To create a journal on you, we would like to ask if you could fill out this form below as well as you can, before entering the medical examination.

Contact information	Navn: Birthday: CellPhone: Email:
Do you have any medical allergies? (f.x are you allergic to penicillin?)	Ingen allergi Allergi mod:
Your position (job)	
Your education	
What is your ethnic background (which country are you from?)	
Marital status (line under)	Married <input type="checkbox"/> Widow <input type="checkbox"/> Cohabitation <input type="checkbox"/> Single <input type="checkbox"/> Other: <input type="checkbox"/>
The date of your last period (the first day)	Dd-mm-yy ...
How long is your cycle (line under, where it fits best to your cycle). If your period is long or doesn't exist in the categories, please write:	(21-28) (28-30) (28-35) (Over 35days) (Under 21 days) Write any cycle length here:
Is it spontaneous pregnancy without medical assistance	Yes No What treatment:
When was your pregnancy positiv the first time?	Date:
Your weight (kg) and height (cm)	Weight: ... kg Height: ... cm.
Do you smoke?	No If Yes: How many per day?
Alcohol	No Inf Yes. how many per week?
Medicin (Write the medicin you take daily)	
Are there any complications during your pregnancy so far? Please emphasize what you have experienced, it is allowed to make more than one line under/cross outside each sentence. →	Bleeding in early pregnancy Preeclampsia (preeclampsia) Placenta Biopsy Amniocentesis Conic operation of the cervix: when? Alcohol, drug consumption that harms fetus
How many miscarriages have you had?	Write the no. here:
How many provocative abortions have you got?	Write the no. here:
Have you been pregnant outside the womb	If yes, write the no. here: Did you get your fallopian tube removed?
How many times have you been pregnant, incl. this pregnancy	Write the no. here:
How many times have you given birth?	Write the no. here:
Have you had the following → Please line under, what you have had, it is allowed to make more than one line.	Fibroid <input type="checkbox"/> Cyst of the ovary <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility Problem <input type="checkbox"/> Cancer: the type of cancer
Have you previously had any surgery on the abdomen? Write year and what type of surgery	
Write a few words about why you have come today	