Registration form

Name: _____ID number: _____Cellphone: _____

Mailing address:_____Civil state: _____ Length:_____Weight:_____

Partner´s Name and cellphone:_____

Date for: Last period (first day)_____Positive pregnancy test_____When did you quit anticontraception: _____

Medications? _____Dosage?_____Vitamins?_____

Allergy?_____

Earlier pregnancies

Health problems	Put an X	**Earlier healthproblems**	Put an X	**Heredity** (Mother/father/siblings)	Put an X
Repeated urine infektions?		Repeated urine infektions?		High bloodpressure	
Epilepsy		Epilepsy		Blood clot (embolism, thrombus)	
Icterus		Icterus		Malformations	
Intestinal disease		Gestational diabetes		Diabetes	
Blood clot (embolism, thrombus)		Blood clot (embolism, thrombus)		Twins	
Mental issues (depression, anxiety etc)		Mental issues (depression, anxiety etc)		Thyroid disease	
Gynecological disease/surgery		Gynecological disease/surgery		Adopted	
Thyroid disease		Thyroid disease			
Lung disease/asthma		Lung disease/asthma			
Rheumatoid arthritis				**Other interventions:**	
GBS bacteria in urine				Breast implant	
Diabetes				Breast reduction	
Chronic kidney disease				Intimate piercing	
Cardiovascular disease				Circumcision	
High bloodpressure				Gastric bypass	
Migrane					

Tobacco/drugs (X)	**Yes**	**No**
Smoking: 3 months before pregnancy		
Smoking today:		
Snuff: 3 months before pregnancy		
Snuff: today		
Other drugs, sleeping pills,etc?		

Do you want:	KUB-test	Yes	No

Do you want	To attend parental class in group		To attend lectures		To attend group for mothers pregnant again	

When did you take SMEAR last time?.....

Do you need to take a chlamydia test?.....