

**VERLOSKUNDIGEN ROTTERDAM WEST**

CENTRUM VOOR VERLOSKUNDE, ECHOGRAFIE, PRECONCEPTIEZORG & ANTICONCEPTIE

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Questionnaire for the first appointment

To prepare for your upcoming appointment, we would like to ask you a few questions. We also offer you some advice regarding your pregnancy. Please complete this questionnaire and bring it with you to your first appointment.

**Please bring your identification and insurance card with you as well.**

**1. Personal information:**

Date of birth: Fill in the date Marital status: Please choose

Maiden/last name: Fill in Partner’s last name: Fill in

First name(s): Fill in Partner’s first name: Fill in

BSN: Fill in Partner’s occupation: Fill in

Address: Fill in

Postcode: Fill in

Home phone number: Fill in Partner’s phone number: Fill in

Cell phone number: Fill in

Email address: Fill in

Ethnicity: Fill in

Religion: Fill in

Occupation: Fill in Work hours per week Fill in

General Practitioner: Fill in

Pharmacy: Fill in

What is your height? (meters) Fill in

What was your weight (kg) before this pregnancy? Fill in

How have you come to know about us? Please choose:

**2. About your health:** **No | Yes**

Do you regularly have arinary tract infection? [ ]  | [ ]

Do you regularly suffer from irritated or bleeding gums? [ ]  | [ ]

Do you regularly suffer from Candida (vaginal yeast infection)? [ ]  | [ ]

Have you ever done a swear test or has there been a swab taken? [ ]  | [ ]

 If yes, when and what was the result? Fill in

Have you ever had chickenpox? [ ]  | [ ]

Do you sometimes get cold sores (herpes labialis) ? [ ]  | [ ]

Have you ever had surgery? [ ]  | [ ]

 If yes, what type and when? Fill in

Have you ever had a blood transfusion? [ ]  | [ ]

Have you had a thrombosis before? [ ]  | [ ]

Have you had a (serious) illness or desease before? [ ]  | [ ]

Do you have allergies? [ ]  | [ ]

 If yes, what type(s)? Fill in

Are you taking prescribed medication? [ ]  | [ ]

 Is yes, which type(s)? how much? *(please bring the packaging with you)* Fill in

Are you allergic to certain medicines? [ ]  | [ ]

If yes, what type(s)? Fill in

Do you ever experience emotional disturbances or depressions? [ ]  | [ ]

Have you been receiving medical treatment from a psychologist or psychiatrist ? [ ]  | [ ]

Do you have or had a STD (sexual disease) [ ]  | [ ]

 If yes, which, when and how was this treated? Fill in

Have you been admitted to a foreign hopital in the past 6 months? [ ]  | [ ]

Does your work involve handling livestock? [ ]  | [ ]

Is someone in your home MRSA positive? [ ]  | [ ]

Have you recently been to a country where ZIKA occurs? [ ]  | [ ]

**3. About your lifestyle:** **No | Yes**

Do you take folic acid? [ ]  | [ ]

 If yes, since when? Fill in

Do you take Vitamin D supplements? [ ]  | [ ]

Do you eat vegetables and fruits daily? [ ]  | [ ]

Do you eat meat, fis hand dairy products several times per week? [ ]  | [ ]

Do you exercise or have moderate to intense physical activity for at least 30 min a day? [ ]  | [ ]

 If yes, what do you do? Fill in

Do you smoke? [ ]  | [ ]

 If yes, how many cigarettes a day? Fill in

Do you drink alcohol? [ ]  | [ ]

 If yes, how much? Fill in

Do you use (non-medical) drugs? [ ]  | [ ]

 If yes, which type(s), how much? Fill in

**4. About your family’s health (parents and siblings):** **No | Yes**

Are there any birth defects or genetic disorders in your family? [ ]  | [ ]

 If yes, which and who? Fill in

Does someone in your family have diabetes? [ ]  | [ ]

 If yes, who, which type and use of medication? Fill in

Does anyone in your immediate family have high blood pressure? [ ]  | [ ]

Do thyroid problems run in the family? [ ]  | [ ]

Does asthma or COPD run in your family? [ ]  | [ ]

Do blood clotting disorders run in your family? [ ]  | [ ]

Are you and this baby’s father blood relatives? (consanguinity) [ ]  | [ ]

 If yes, what is your relationship with each other? Fill in

**5. About the health of this baby’s biological father** **No | Yes**

Are there any birth defects or genetic disorders in his family? [ ]  | [ ]

 If yes, which and who? Fill in

Does he have allergies? [ ]  | [ ]

If yes, what type(s)? Fill in

Does he smoke? [ ]  | [ ]

 If yes, we strongly advise him not to smoke in the house or in your vicinity.

Does he have children from another relation? [ ]  | [ ]

If yes, are they healthy? [ ]  | [ ]

**6. About current pregnancy:** **No | Yes**

What was the first day of your last menstrual period? Vul datum in

Have you been taking the birth control pill before this pregnancy? [ ]  | [ ]

 If yes, untill when? Vul datum in

Have you used another contraceptive? [ ]  | [ ]

If yes, which, what and untill when? Fill in

Did you have a regular menstrual cycle +/- 28 days? [ ]  | [ ]

If **no**, what was the lenght of your menstrual cycle in days? Fill in

Have you done a pregnancy test? [ ]  | [ ]

If yes, when and what was the result? Fill in

Have you undergone a fertility treatment? [ ]  | [ ]

**7. About previous pregnancies:** **No | Yes**

Have you ever been pregnant before? [ ]  | [ ]

**If no, then please skip this part of the questionnaire and continue on the next page, starting at: “ 8. About your social situation.”**

Have you ever had a miscarriage? [ ]  | [ ]

If yes, how many, where and when (mention weeks of pregnancy and year)? Fill in

Were you seen by a midwife, G.P. or gynecologist back then? [ ]  | [ ]

Have you had a curretage (D&C/suction) done? [ ]  | [ ]

If yes, in which hospital? Fill in

Had there been any complications? [ ]  | [ ]

Have you ever had an abortion? [ ]  | [ ]

If yes, how many times and when? Fill in

Where there any complications? [ ]  | [ ]

How many children have you conceived? Fill in

**Please fill in the required information for each one of your children**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Child 1** | **Child 2** | **Child 3** | **Child 4** |
| **Date of birth:** |  |  |  |  |
| **Gender:** |  |  |  |  |
| **Name:** |  |  |  |  |
| **Due date: (weeks pregnant)** |  |  |  |  |
| **Weight at birth:** |  |  |  |  |
| **Problems during the pregnancy:** |  |  |  |  |
| **Problems during delivery:****Delivery type:** |  |  |  |  |
| **Place of delivery: (home / hopital)** |  |  |  |  |
| **Problems after delivery, during post-natal period:** |  |  |  |  |
| **Breast or bottle feeding:**  |  |  |  |  |

Have you had a stillbirth or has any of your children passed away during or after childbirth, or in early childhood? [ ]  | [ ]

If yes, when did this happen, and what was the cause? Fill in

**8. About your social situation:**

**Ethnicity:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yourself:** | **Baby’s father:** | **Your mother:**  | **Your father:**  |
| **Place of birth:** |  |  |  |  |
| **Ethnicity:** |  |  |  |  |

**Education:**

Completed highest education level:

 **You: Your partner:**

**Low (no education/ primary school):** [ ]  [ ]

**Medium (VMBO / MBO / HAVO / secondary school):** [ ]  [ ]

**High: (college / university):** [ ]  [ ]

**Your financial and employment situation:** **No | Yes**

Do you have a (paid) job during the first trimester of your pregnancy? [ ]  | [ ]

Does your work involve standing long hours without moving much? [ ]  | [ ]

If yes, how many hours a week? Fill in

Do you experience stress at work?

 No [ ]

 Sometimes [ ]

 Often [ ]

 Very often [ ]

 Always [ ]

**Income sources or financial means to support the pregnancy:**

 **You: Your partner:**

**Work:** [ ]  [ ]

**Social benefit:** [ ]  [ ]

**None / N.A.**  [ ]  [ ]

 **Combined monthly net income of the household to which you (pregnant mother) belong(s):**

 **No | Yes**

Is the combined net income of you and your partner less than €1000,- per month?

 [ ]  | [ ]

Do you have financial debt that must be paid off? [ ]  | [ ]

**Have you been abused in the past?**

Have you ever experienced any sexual abuse? [ ]  | [ ]

Have you ever experienced any domestic violence or abuse? [ ]  | [ ]

Has your partner ever been abused? [ ]  | [ ]

In the past 2 years, have you been in contact with Bureau Jeugdzorg ? [ ]  | [ ]

**How many people can you turn tof or social support?**

 None [ ]

 1 - 2 [ ]

 3 or more [ ]

**Have you been given any preconception advice?** [ ]  | [ ]

If yes, who gave you the advice? Fill in

**This pregnancy is:**

 Planned [ ]

 Unplanned, but desired [ ]

 Unplanned, not specifically desired [ ]

**We thank you for completing this questionnaire. Your answers will be discussed during the first checkup. Naturally, all your answers and information will be treated confidentially and used for medical purposes only.**