Robert-Bosch-Krankenhaus

Obstetric questionnaire

We are very pleased that you have chosen us to take care of you when giving birth. We find it very helpful if you drop by and introduce yourself to us before the birth. Please complete the following questionnaire and bring it along when you come to visit us.

If you are unclear about anything or have any questions or personal wishes, you will of course be able to express these personally with one of our doctors or midwives.

name, surname | date of birth | occupation

address | telephone number

name of next of kin | telephone number of next of kin

supplementary insurance

☐ no
☐ yes single/twin room, inpatient/outpatient, head doctor?

gynecologist attended | name of your aftercare midwife

family name of the baby | height | What was your weight at the beginning of the prenancy? What is your weight now?

Do you have any allergies?

Have you taken any medication during your pregnancy? (including iron, magnesium or other preparations)

Have you ever had a transfusion before? What was the reason?

Do you smoke? If yes, how many are you currently smoking and how many did you smoke before the pregnancy?

Did you consume alcohol during the pregnancy?

Robert-Bosch-Krankenhaus
Auerbachstraße 110, 70376 Stuttgart
www.rbk.de
ID: 45972
Version: 002/11.2021

Abteilung für
Gynäkologie und Geburtshilfe
Prof. Dr. med. Georg Sauer
Chefarzt

Gynäkologische Ambulanz
Telefon 0711/8101-5144
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Robert-Bosch-Krankenhaus

Current Pregnancy

How regular was your menstrual cycle before the pregnancy? _____

How many days were there between the first day of bleeding to the beginning of the next cycle? _____

How many days did you bleed for? _____

Did you take any hormones before the pregnancy? (e.g. contraception, the pill, the coil, vaginal ring etc.) If yes, what did you take and until when?

_____

Did you naturally get pregnant or did you get hormonal help?

_____

Have you ever had a miscarriage or a termination?

year	**In which month of pregnancy ?**	**Curettage?**

Has anything specific happened in your pregnancy so far? _____

_____

Previous Births

date	natural birth forceps, caesarean operation	boy, girl	weight, length	duration of birth	clinic	particularities (inducing, birth injury, early birth, reason for caesarian/forceps, bleeding)

Robert-Bosch-Krankenhaus

Health history

Do you suffer from any of the following illnesses:

High blood pressure? _____

Diabetes? _____

Thyroid problems? _____

Blood clotting (thrombosis)? _____

Kidney disease? _____

Mental disorders or stress? _____

Hip problems (e.g. hip dysplasia as a child)? _____

Any other relevant information _____

Have you ever had an operation?

year	type of surgery	anesthesia

Were you hospitalised during your pregnancy?

_____ _____ _____

reason for stay | duration of stay | clinic

Have you been in contact with MRSA/MRGN? (multi resistant germs)? ☐ no ☐ yes

Have you been an inpatient at a clinic in the last twelve months? ☐ no ☐ yes

Have you taken antibiotics in the last six months? ☐ no ☐ yes

Have you been in a clinic in Greece, Turkey, India or Israel in the last twelve months? ☐ no ☐ yes

Vaccination against COVID-19

Gravida: ☐ no ☐ yes, dates of both injections: _____

Companion for the birth: ☐ no ☐ yes, dates of both injections: _____

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Family health history

Does the father of the child or his close family or your family have any illnesses? If yes, what illnesses and who has them?

Blood Pressure? _____

Diabetes? _____

Thyroid problem? _____

Blood clotting (Thrombosis)? _____

Kidney disease? _____

Mental disorder? _____

Hip problems? _____

Hereditary diseases? _____

Any other illness or peculiarity? _____

Do you have any other wishes or particulars you would like to inform us about?

_____

We would like to thank you for taking the time to fill out this questionnaire and wish you all the best during the rest of your pregnancy.

Your delivery room team

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