

Health declaration pregnancy

Before your first visit to the midwifery clinic, it is important to answer certain questions that are necessary for your care during your pregnancy. Therefore, we ask you to fill in this health declaration. The information provided on this page is subject to confidentiality and the only people who are allowed to read the information are staff involved in your care for this pregnancy. Bring your identification card.

My contact details

Name: _____
Address: _____
Telephone number: _____

Partner/next of kin: _____
Relationship: _____
Telephone number: _____

In which country were you born? _____
If you were not born in Sweden, how long have you lived here? _____
Do you need an interpreter? No Yes, language: _____

When did you have your last period (First day of bleeding)? Cycle length? _____

Have you taken a pregnancy test? Date? _____

Have you recently used contraception? Method? _____
When did you stop? _____

Do you have any allergies? Yes, to what?: _____
 No

Do you use nicotine (e.g., smoking, snuffing, smoking hookah) or drugs? Yes: _____
 No

Describe your social situation:

Cohabiting with the child's other parent: Yes
 No
Other situation: Yes: _____

Problems with work and/or housing: Yes
 No

Occupation, Full-time Part-time

gainfully

employed

Current place of
work/education:

Jobseeker/

Student/other?

Educational
background:

- None or schooling shorter than 9 years
 Primary and lower-secondary school (or equivalent)
 Up to and including upper secondary school (or equivalent)
 College/University (or equivalent)

Have you been
trying to get
pregnant for more
than 1 year?:

Have you
received help
from the
healthcare system
to get pregnant?

Previous pregnancies and deliveries

Miscarriage:
Year, month,
pregnancy week:
Hospital, some
complications?

Abortion:
Year, month,
pregnancy week:
Hospital, some
complications?

Deliveries:

Year, month	Pregnancy week	Sex	Weight	Hospital	Describe complications, if any

Describe
breastfeeding
experience, if any:

Is there any heredity in your families that may have a bearing on pregnancy and childbirth? For example, blood clots, hemophilia, malformation, thyroid disease.

Yes, describe: _____

No

Your physical health

Do you have or have you had any of the following illnesses?

Cardiovascular disease/coagulation disorder, such as heart valve disease, myocardial infarction, hypertension, blood clots.		Gastrointestinal disease, such as ulcerative colitis, Morbus Crohn.	
Mental disorders, such as anxiety, depression, eating disorder, bipolar disorder, ADHD, autism.		Diabetes.	
Liver disease, such as jaundice, biliary disease.		SLE or other rheumatic disease.	
Any disease transmissible through blood, such as hepatitis, HIV.		Epilepsy.	
Gynecological disease, such as herpes, endometriosis, fibroids.		Joint or muscle disease, such as MS, rheumatism, back problems.	
Endocrinological disease, such as goiter, adrenal/pituitary disease.		Headache, migraine.	
Urinary tract problems, such as urinary tract infection, kidney disease.		Resistant bacteria, such as MRSA.	
Lung disease, for example asthma, bronchitis, TB.		Ongoing wound infection.	

Other:

When was the last time you had a pap smear test? (Date, cell changes, if any):

Do you use any medications or health food products?

Yes, which ones and dose: _____

No

Have you had X-rays or vaccinations since you became pregnant?

Yes, when, describe: _____

No

Have you ever received a blood transfusion?

Yes, when?: _____

No

Have you undergone any surgery?

Yes, please describe in more detail:

No

Are you or have you been in contact with a counselor, psychologist, or social welfare officer?

Yes, please provide contact details: _____

No

Other/anything else you wish to convey?

Feel free to describe your thoughts on pregnancy/childbirth:

How do you rate your state of health in the last three months before this pregnancy?

Very good
 Good
 Neither good nor bad
 Bad
 Very bad
 Do not know

I consent to integrated record-keeping (that the healthcare provider may access documentation from another healthcare provider)

Yes
 No
 I don't know, I would like to receive more information

Do you agree that samples are saved in Biobank? Yes
 No
 I don't know, I would like to receive more information

Do you agree to be included in the Swedish Pregnancy Register? Yes
 No
 I don't know, I would like to receive more information