praenatalschall.de
Praxis für pränatale Diagnostik München

Dear Patient,
The personal consultation is important and is not intended to be replaced by this form, but instead be facilitated in terms of time. All information provided is subject to doctor-patient confidentiality, which also applies to all information provided in this questionnaire. Please help us by filling it out carefully.

Name:	First name:
Date of birth:	Profession:
Address (street, house number, postcode and town)	
Tel. no. home:	Insurance:
Tel. no. mobile:	Referring doctor:

First day of last period (date)	Regular cycle no O yes O Abnormal bleeding yes O no O
Cycle duration (days from period to period): Period duration (days of bleeding):	Ovulation trigger? yes O no O (was ovulation triggered by medication)
Problems during the **current** pregnancy and any in-patient stays?	**Preliminary examinations** and results (please mark with a cross) **Nuchal fold scan (O +biochemical test)** **yes O no O** Unremarkable yes O no O **PraenaTest, PanoramaTest, HarmonyTest** **yes O no O** Unremarkable yes O no O **Procedures (amniocentesis / CVS)** **yes O no O** Unremarkable yes O no O **Malformation ultrasound** **yes O no O** Unremarkable yes O no O
Has **artificial insemination** taken place? yes O no O If yes: which method?_____ Cryopreservation? yes O no O Please specify day of puncture_____ Transfer_____if yes: Date of freezing:_____	
Size:	Nicotine yes O number of cigarettes:_____ no O
Current weight:	Alcohol yes O Amount:_____ no O
Are you and your partner related by blood? yes O no O (e.g. cousins)	Other infections? yes O with: _____ no O Is there an infection with Hepatitis A/B/C? yes O no O

Allergies:	Current **medication** (preparation / dose) ASA or Heparin (blood thinning) yes O no O Folic acid? O yes O already before pregnancy no O Others:

Births (in each case year / gender / birth weight / type of delivery)	Problems with **previous** pregnancy / birth
	Miscarriages (year, week of pregnancy)
Ectopic pregnancy (year)	Termination (year)

Other conditions (diabetes, high blood pressure, thrombosis, cancer etc.)	Conditions in the family (including the child's father's family) (hereditary disorders, heart conditions since birth etc.)
Gynaecological and other operations (year / type)	

I hereby confirm having received the patient information about data protection

Signature: ……..……..……...