

# Welcome to the midwife clinic!

Please fill in this health questionnaire and bring it to your next visit.

Expectant mother		Personal Identity number:			
Name:		Address:			
Phone:					
Occupation:		Workplace:			
Country of Birth:		Language (if not swedish)/interpreeter needed:			
Partner/next of kin					
Name:		Address (if different from above):			
Phone:					
Occupation:		Workplace:			
Home and work					
Family situation: <input type="checkbox"/> Married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Single <input type="checkbox"/> Other					
Employment: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Student					
<input type="checkbox"/> Parental leave <input type="checkbox"/> Job-seeking <input type="checkbox"/> Sick leave					
Education level: <input type="checkbox"/> Less than 9 years <input type="checkbox"/> Primary school <input type="checkbox"/> High school <input type="checkbox"/> University					
Work or housing problems: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Menstruation bleeding and Current pregnancy					
Date of first date of last menstrual period:			Do you have regular periods? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Number of days bleeding usually lasts:			Number of days from first day of period to next period :		
Years trying to conceive:			Treatment to become pregnant:		
Date of positive pregnancy test:			<input type="checkbox"/> None <input type="checkbox"/> IVF <input type="checkbox"/> Other:		
Date you stopped using contraception:					
Previous pregnancies and deliveries(including misscariage/abortion)					
Year/month	Sex	Birthweight	Gestational week	Hospital	Complications
How would you rate your health during the three months before pregnancy?					
<input type="checkbox"/> Very good		<input type="checkbox"/> Good		<input type="checkbox"/> Neither good nor poor	
				<input type="checkbox"/> Poor	
				<input type="checkbox"/> Very poor	



Lifestyle habits						
Tobacco and nicotine:						
Tobacco 3 months before pregnancy		<input type="checkbox"/> cigarettes, number/day:		<input type="checkbox"/> Snus		<input type="checkbox"/> No
Smoking today		<input type="checkbox"/> cigarettes, number/day:		<input type="checkbox"/> Snus		<input type="checkbox"/> No
Drugs 3 month before pregnancy		<input type="checkbox"/> Yes			<input type="checkbox"/> No	
Drugs today		<input type="checkbox"/> Yes			<input type="checkbox"/> No	
Alcohol 3 months before pregnancy		<input type="checkbox"/> Rarely/never		<input type="checkbox"/> Max once/week		<input type="checkbox"/> Moore than once/week
Alcohol today		<input type="checkbox"/> Rarely/never		<input type="checkbox"/> Max once/week		<input type="checkbox"/> Moore than once/week
Current weight:		kg		Height:		cm
Do you use tobacco snuff, nicotine snuff, cigarettes, water pipes, e-cigarettes, nicotine medicines or other tobacco or nicotine products?						
	Daily or almost daily	How much?	Sometimes	How much?	Stopped	End date
Tobacco snus	<input type="checkbox"/>	_____ doses/week	<input type="checkbox"/>	_____ doses/month	<input type="checkbox"/>	
Nicotine snus	<input type="checkbox"/>	_____ doses/week	<input type="checkbox"/>	_____ doses/month	<input type="checkbox"/>	
Cigarettes	<input type="checkbox"/>	_____ doses/week	<input type="checkbox"/>	_____ doses/month	<input type="checkbox"/>	
Water pipes	<input type="checkbox"/>	_____ doses/week	<input type="checkbox"/>	_____ doses/month	<input type="checkbox"/>	
E-cigarettes	<input type="checkbox"/>	_____ doses/week	<input type="checkbox"/>	_____ doses/month	<input type="checkbox"/>	
Nicotine medicines (chewing gum,plasters)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Other tobacco or nicotine products	<input type="checkbox"/> What? _____		<input type="checkbox"/> What? _____		<input type="checkbox"/> What? _____	

Have you/do you have any of the following diseases/conditions?	Yes	No
Cardiovascular disease (e.g., high blood pressure, valve disorder, heart attack, bleeding tendency)		
Blood clot		
Mental health issues (e.g., anxiety, depression, eating disorder, obsessive-compulsive disorder)		
Neuropsychiatric diagnosis (e.g., ADHD, autism, Asperger)		
Liver disease (e.g., jaundice, gallstones)		
Gynecological disease or surgery		
Herpes, oral and/or genital		
Does your partner have known genital herpes?		
Hormone-related disease (e.g., thyroid disorder, adrenal or pituitary disease)		
Urinary tract infection treated with antibiotics (during the past year)		
Kidney disease		
Lung disease/asthma		
Inflammatory bowel disease (ulcerative colitis, Crohn's disease)		
Diabetes or prediabetes		
SLE (systemic lupus erythematosus – inflammatory connective tissue disease)		
Epilepsy		
Joint or muscle disease (e.g., rheumatism, back problems)		
Chronic headache/migraine		
Allergy/intolerance (specify to what)		
Other illness/previous surgery (specify what)		
Do you have breathing pauses while sleeping?		
Have you ever received a blood transfusion? If yes, which year?		
Have you visited a healthcare facility abroad in the past 6 months?		
Have you or any close relative had tuberculosis?		
Have you stayed for more than 3 months in a country outside Sweden? Which country?		
Are you planning to travel abroad during the first six months after delivery? Where?		
Do you have a cough or fever lasting more than 2 weeks, weight loss, or night sweats?		
Have you had a gynecological smear test? If yes, when was the most recent one?		
Are you circumcised/genitally mutilated?		
Have you used any medications/vitamins/herbal remedies during pregnancy? Please specify name, dose, and gestational week.		
Have you been vaccinated during pregnancy? If yes, against what and when?		
Have you had an X-ray during pregnancy? If yes, when?		
Has your mother or sister had preeclampsia (pregnancy-induced hypertension)?		
Family history (mother/father/siblings, also partner's relatives) for example bleeding disorders, blood clots, high blood pressure, malformations, diabetes, thyroid disease, mental illness, twins.		