BB Stockholm Family

We are grateful if you would fill out this form and bring it to your first visit with us. Please bring some form of identification also.

Name:_____
Birthdate/Personnummer:_____
Birth country:_____
Address:_____
Phone#home:_____Cell:_____
E-mail:_____
Living together with the partner partner Yes ☐ No ☐ Other situation ☐
Occupation/work: Full time ☐ Part time ☐ Unemployed ☐ Studying ☐
Profession:_____Workplace:_____
Education: High school ☐ University ☐
Work or living related problems: Yes ☐ No ☐
Partner/other relative name: _____
Address (if not the same)_____
Cell: _____
Weight (before pregnancy):_____ Height:_____
Last menstrual period:_____
How long does your period last:_____
Interval between periods:_____
Pregnancy test positive - date:_____
Tried to get pregnant:_____years
Received help to get pregnant: Yes ☐ No ☐ (method): _____
If IVF or ICSI - date for ET:_____

Earlier pregnancies and birth:

Write down your earlier pregnancies and births, what year and month you gave birth, sex, birth weight of your baby, what pregnancy week you gave birth and if there were any complications with your pregnancy or birth.

Did you have any miscarriages or legal abortions? Please write down these also.

Year/month	Sex	Hospital	Weigth	Pregnancy week	Complications?

Breastfeeding experience:_____
Did you take any medication since you got pregnant? Yes ☐ No ☐
If yes – what? .... When? .....
Are you taking any medication/vitamins at present? Which? .....
Smoke: Yes ☐ No ☐ Stopped when pregnant: Yes ☐ No ☐
No of cigarettes before pregnant ..... No of cigarettes now: .....

Deaseses in your family

Has anyone in your immediate family (mother, father, siblings) have or had any of the following diseases?	**Yes**	**No**	**If yes who?**
High blood pressure			
Blood clots			
Haemophilia			
Thyroid disease			

Deseases that you have or have had?

Heart- coronary disease	**Yes**	**No**
Blood clot		
Psychiatric disease		
Hepatitis		
Gynaecological disease		
Metabolic disease, ex thyroid		
Urinary tract infection		
Lung disease or Asthma		
Kidney disease		
Inflammatory disease of intestines		
Diabetes		
Arthritic disease		
Epilepsy		
High blood pressure		
Allergy		
Eating disorder, anorexia, bullemia		
Surgery		

Other

Are there twins in your immediate family Yes ☐ No ☐
Have you been x-rayed or vaccinated since you got pregnant? .....
Have you ever had a blood transfusion? ..... When? .....
Did you have any surgery? Yes ☐ No ☐
Did you have any surgery done to your genitals or FGM? Yes ☐ No ☐
Have you been exposed to domestic violence? Yes ☐ No ☐
Have you been in contact with a counselor or social secretary the last year? Yes ☐ No ☐
Have you been visiting any healthcare facility abroad during the last 6 month? Yes ☐ No ☐
Do you have MRSA? Yes ☐ No ☐
When was the last papp smear? ..... ……
How did you perceive your general state of health three months before pregnancy?
Very good □ Good □ Neither good or bad □ Bad □ Very bad □ I don´t know □

Would you like to add anything?

We wish you a warm welcome at your visits to us!