VASAMAMMA
Barnmorskemottagning

Please fill out this form and bring it to your first visit with us.
Please bring some form of identification also.

Mother:

Personalnumber: _____

Name: _____

Phonenumber: _____

Adress:_____

Mailadress:_____

Education: Elementary school ☐ Highschool ☐ Universitet ☐

Titel:_____

Company:_____Full time ☐ Part time ☐

In what country are you born? _____

Do you live together with the father to be? _____

Work or living related problems?_____

Father to be/Partner:

Name: _____

Phonenumber: _____

Adress:_____

Mailadress:_____

Education: Elementary school ☐ Highschool ☐ Universitet ☐

Titel:_____

Company:_____ Full time ☐ Part time ☐

First day of last menstrual period? _____

Interval between periods? _____

How long does your period last? _____

Did you use any antikonception before pregnancy? What kind?_____

Weight: _____ Height:_____

Last smear test? _____

How will you describe your health the last 6 months?

Very good ☐ Good ☐ Either good or bad ☐ Bad ☐ Very bad ☐ Dont know ☐

Do you smoke? *If yes, how many/day?*
Alcohol? *How many times/week?* Alcohol before pregnancy? *How many times/week?*
Have you been using any drugs the last sex months? *If yes what?*

	Yes	**No**
Have you been trying to get pregnat more than one year? *If yes, How many?*		
Received help to get pregnant?		
What kind om method was used? Expected date?		

I give my permission to open other journals related to my pregnancies		

Earlier pregnacies and birth, miscarriages or abortions.

Year/month	Pregnacie type (IVF)	Gender	Weight	Week	Hospital	Vaginal/sectio

Have you or have had any of these diseases:	**Yes**	**No**
1. Heart – coronary disease, *for example bloodclot*		
2. Psychiatric disease		
3. Liver disease		
4. Blooddisease , *hepatit, HIV*		
5. Gynecological disease		
6. Metabolic disease		
7. Urinary tract infection		
8. Lungdisease *t.ex. astma, bronkit, tbc*		

	Yes	No
9. Inflammatory disease of the intestines *Ulceres colit, Morbus Chron*		
10. Diabetes		
11. Arthritic disease		
12. Epilepsy		
13. High blood pressure?		
14. Headace, migraine		
15. Allergy? *Against what?*		
16. Have you visit a medical institution abroad within sex months?		
17. MRSA? *(stafylokockinfektion)*		
18. Any other disease?		
19. Have you ever had any surgery? What?		
20. Have you had any contact whith a counselor or psychologist?		
21. Have you experienced violence in a close realtionship?		
22. Have you been x-rayed during your pregnancy?		
23. Have you ever had a bloodtransfusion?		
24. Does anyone in your family have/ had: Thyroid, blood disease, high blood presure, twins, diabetes, or other hereditary disease.		

Do you take any medicin at the moment?

Name	mg/ug	Dose	Name	Styrka	Dose

Other importat information:

_____

_____

_____

_____

How did you find Vasamamma?

Recommendations ☐ Internet ☐ Other ☐_____