Mother-to-be:

Name: _____

First name: _____

Date of birth: _____

Address: _____

Telephone: _____

Identity card number: _____

Health insurance: _____

Occupation: _____

Father of the child: _____

Name: _____

First name: _____

Date of birth: _____

Telephone: _____

Occupation: _____

Family-related diseases:

Body height: _____

Weight: _____(at the beginning of pregnancy)

_____(at the end of pregnancy)

Own diseases: _____

_____

_____

Drugs (+ dosage): _____

_____

_____

Allergies: _____

If so, what reaction was observed? _____

previous operations: _____

previous blood transfusions: _____

Current gynecologist: _____

Current midwife: _____

Prenatal diagnostics /Dr: _____

Previous pregnancies (miscarriage, abortion, births):_____

_____

_____

_____

_____

Course of this pregnancy (including hospital admisions):

_____

_____

_____

_____

Last menstruation: _____

Estimated date of delivery: _____

Wish to Breastfeed: _____

Experience in Breastfeeding: _____

_____

_____

Abnormalities during former postpartum periods:

_____

_____