Ålands hälso- & sjukvård

MATERNITY CLINIC

ADVANCE INFORMATION to the maternity clinic

DETAILS OF THE MOTHER-TO-BE	Family name (also previous names)	All first names	
	Address	Postcode and town	Social security number
	Phone number home/mobile	Phone number work	Native language
	Civil status (married, cohabiting, other)	Profession	Employer
	Country of birth	Place of residence (municipality)	Religion
DETAILS OF THE FATHER-TO-BE/PARTNER	Family name (also previous names)	All first names	
	Address ☐ same as mother-to-be	Postcode and town	Social security number
	Phone number home/mobile	Phone number work	Native language
	Profession	Employer	Country of birth
	Religion		
CHILDREN IN THE FAMILY (name/year of birth)	Common children	Children from previous relationships	
	_____	_____	
	_____	_____	
	_____	_____	
ADVANCE INFORMATION ABOUT THE MOTHER-TO-BE	Last menstruation, date _____	Pregnancy test positive, date _____	
	Length of menstrual cycle _____ days ☐ regular ☐ irregular		
CONTRA-CEPTION	What contraceptives did you use before your pregnancy?		
	When did you stop using contraceptives? Date		
SMEAR TEST (CERVICAL SCAN)	Last smear test, date		
HEIGHT AND WEIGHT	Height _____ cm and weight _____ kg before pregnancy		
FERTILITY TREATMENT	Fertility treatment prior to pregnancy? What kind?		
	Date of fertilization/embryo transfer		
MEDICATION	Do you take any medicines regularly? Which/what dose?		

PREVIOUS PREGNANCIES AND CHILDBIRTHS	Date and year of the last child-birth	Aborted preg-nancy, which week?	Gen-der	Living (L), Still-born (DF), Dead (D)	Weight at birth in grams	Description of pregnancy, childbirth and new-born period	Length of preg-nancy in weeks	Length of labour in hours	Length of breast-feeding in months	Where was the child born?

SERIOUS ILLNESSES OF PARENTS

M = MOTHER
P = FATHER

M	P		M	P		M		M	
☐	☐	Diabetes	☐	☐	Respiratory disease	☐	Urinary infection	Gynaecological disorders	
☐	☐	Blood pressure	☐	☐	Epilepsy	☐	Thyroid disease	☐	Operations
☐	☐	Allergies	☐	☐	Neurological disease	☐	Rheumatism	☐	Tumours
☐	☐	Kidney disease	☐	☐	Mental illness	☐	Operations	☐	Infertility
☐	☐	Heart disease	☐	☐	Depression, burnout	☐	Chickenpox	☐	Hormonal treatment
☐	☐	Liver disease	☐	☐	Congenital deformities	☐	Rubella	☐	Sexually transmitted diseases
☐	☐	Haemophilia	☐	☐	Handicap/visual or hearing defect	☐	Blood transfusion	☐	PCO
			☐	☐	Genital herpes	☐	Eating disorders	☐	Hospital treatment outside Åland
			☐	☐	Other	☐	Migraine headaches		
						☐	Varicose veins	☐	Other

Further information about the mother´s illnesses and places of treatment

ILLNESSES IN THE FAMILY

Serious illnesses in the family
(deformities, congenital illnesses in children, father, siblings, grandparents)

TUBERCULOSIS VACCINATION

We need to know whether someone in the family was born abroad, in case the new-born requires vaccination against tuberculosis

☐ no ☐ yes, which country? _____

Are you planning to live abroad during the child´s first year?

☐ no ☐ yes, which country? _____

Is there anyone in your family who has or has had tuberculosis?

☐ no ☐ yes, who? _____

I/we give my/our permission that this information be entered in the child´s medical records.

☐ yes ☐ no Signature of mother _____

☐ yes ☐ no Signature of father/partner _____

Date _____