Patient Name: **<PATIENT NAME>** Patient Date of Birth: **<DOB>**

Patient Former Names:**<FORMER NAME>** Pregnancy Delivery Date: **<DOFDEL>**

Patient’s Pregnancy Number: **<PregNUM>** Pregnancy year: **<YEARPREG>**

**Pregnancy Course**

|  |  |  |
| --- | --- | --- |
|  |  | If no, please describe. |
| Normal Pregnancy | YesNo |  |
| Normal Labor | YesNo |  |
| Normal Delivery | YesNo |  |
|  |  | If C-Section, please indicate reason. |
| Delivery Type | VaginalC-Section |  |

**Drugs during pregnancy**

|  |  |  |
| --- | --- | --- |
| Drug Name | Dose/day | Actual Time taken during pregnancy(e.g., weeks 1 – 5 and 20 – 32) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Pregnancy Complication(s)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  | Date | Reason |
| Live Birth | No | Yes |  |  |
| Spontaneous Abortion | No | Yes |  |  |
| Induced Abortion | No | Yes |  |  |
| Therapeutic Abortion | No | Yes |  |  |
| Other (please describe) | No | Yes |  |  |

Date completed:

This form was completed by:

**FOR STAFF USE ONLY:**

Entered by: Date:

Entered by: Date:

  <PHYSICIAN NAME>  A Qualified Staff Member:

 Specialty: <SPECIALTY> Name, Qualification

**Thank you for supporting your patient’s participation in this study.**