

Anamnesebogen

Geburtshilfliche Abteilung

Patient	Husband (if you are not married, you don't have to fill it out)
Name:	Name:
Surname:	Surname:
Name of birth:	Name of birth:
Date of birth:	Date of birth:
Address:	Date of marriage:
	Place of marriage:
Phonenumber:	Phonenumber:
Job:	Job:
Working while pregnancy?	How many children do you have with your wife?
Nationality:	Nationality:
Religion:	Religion:
Gynecologist:	Thrombosis tendency/coagulation disorder?
Aftercare midwife:	Allergies? Which?
Private insurance? 1-bed room <input type="checkbox"/> 2-bed room <input type="checkbox"/> With Chiefdoctor <input type="checkbox"/> without chief doctor <input type="checkbox"/>	Illnesses? Which?
Do you want a family room? yes <input type="checkbox"/> no <input type="checkbox"/>	
nursing: yes <input type="checkbox"/> no <input type="checkbox"/>	Do you smoke? How many cigarettes a day?
Medication:	
	Did you have any surgeries in the past? Which surgery and when?

Birth (please name us the date of birth of your children)

Date of birth	Week of pregnancy	Weight	Birth mode (miscarriage?)	Injuries	Anästhesia	Labor induction?	Breast feeding?