Repeated miscarriages questionnaire

Surname, First name

Date of birth

Street/house No.

Postcode/Town

Land line No.

Mobile phone No.

E-mail address

Profession

Who is your family doctor?

Who is your gynaecologist?

Previous pregnancies

Month/Year		Natural birth (N) or Caesarean section (C)		Mis-carriage	Abortion	Fallopian tube pregnancy	In this partnership	Through fertility treatment	Compli-cations
		N	C						
		N	C						
		N	C						
		N	C						
		N	C						

Comments:

Miscarriages

Month/Year		Week of pregnancy	Heartbeat detectable		Drug treatment during pregnancy	Curettage	
			Yes	No		Yes	No
			Yes	No		Yes	No
			Yes	No		Yes	No
			Yes	No		Yes	No

Comments:

When was your last cancer screening?

Have you had pelvic inflammatory disease?

Yes If yes, since when? How was it treated? No

Cycle and hormone history

How often do your monthly periods currently occur?

Approx. every ____ days ____ weeks ____ months

Do you have intermenstrual bleeding/spotting?

Yes ☐ No ☐

Have you noticed secretions coming out of your breasts, regardless of pregnancy or breastfeeding?

Yes ☐ No ☐

If yes, since when? ____

One side ☐ Both sides ☐ Colour ____

Have you noticed any of the following symptoms?

Increase in body hair	Yes ☐	No ☐
Acne	Yes ☐	No ☐
Increased hair loss	Yes ☐	No ☐

Has your thyroid already been investigated?

Yes ☐ If yes, when? ____ No ☐

If yes, by which method?

Ultrasound ☐ Radiology ☐ Blood test ☐

What were the findings?

Do you take thyroid medication?

Yes ☐ No ☐

If so, which medication?

Further history

Do you have any pre-existing conditions?

Yes ☐ No ☐

Which pre-existing conditions?

- Thromboses/pulmonary embolisms ☐
- High blood pressure ☐
- High blood lipid levels ☐
- Cardiovascular problems ☐
- Kidneys/liver/lungs ☐
- Diabetes ☐
- Infections (e.g. hepatitis, HIV) ☐
- Migraine ☐
- Mental health problems ☐

Other/comments:

Do you take medication regularly?

Yes ☐ No ☐

If so, please give details.

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Weight (kg)

Height (cm)

BMI

Do you have any allergies?

Yes No

If yes, which?

Do you smoke?

Yes No

If so, how much? Cigs/day

Do you drink alcohol?

Yes No Occasionall Regularly

Do you take drugs?

Yes No Occasionall Regularly

If yes, which drugs?

Have you already undergone surgery?

Yes If yes, what/when? No

Surgery	Year

Family history

Do you have a family history of hereditary diseases, cancer or other serious illnesses?

Yes On my mother‘s side (who?) No

Yes On my father‘s side (who?) No

Does your family suffer from infertility, recurrent miscarriages or stillbirths?

Yes On my mother‘s side (who?) No

Yes On my father‘s side (who?) No

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Partner's details

Surname, First name

Date of birth

Do you suffer from serious pre-existing conditions, hereditary diseases or metabolic disorders?

Yes No

If so, which conditions?

Do you take medication regularly?

Yes No

If yes, which?

What is your weight and height?

Weight (kg)

Height (cm)

BMI

Do you smoke? Yes No

If so, how much? Cigs/day

Do you drink alcohol? Yes No

Occasionally Regularly

Does your family suffer from recurrent miscarriages or stillbirths?

Yes On my mother's side (who?) No

Yes On my father's side (who?) No

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