



## // Birth registration form

All information is voluntary and  
will be treated confidentially!



### Personal details

Name \_\_\_\_\_ First name \_\_\_\_\_

Maiden name \_\_\_\_\_ Date of birth \_\_\_\_\_ Place of birth \_\_\_\_\_

Address \_\_\_\_\_

Postal code + city \_\_\_\_\_ Phone \_\_\_\_\_

Nationality \_\_\_\_\_ Religion \_\_\_\_\_

Member of a statutory health insurance  Consultant treatment Inpatient   
private health insurance  Outpatient   
Name of health insurance \_\_\_\_\_

Occupation during this pregnancy No  Yes

Profession (including housewife) \_\_\_\_\_

Occupation perceived as a burden? No  Yes

### Information about the accompanying person (voluntary)

Name \_\_\_\_\_ First name \_\_\_\_\_

Date of birth \_\_\_\_\_ Place of birth \_\_\_\_\_

Address \_\_\_\_\_ Occupation \_\_\_\_\_  
(if different)



### Information about the expectant mother

Do you have any specific medical conditions or serious general health conditions  
(heart, liver, kidney, stomach, intestines, hypothyroidism)?

No  Yes  \_\_\_\_\_

Are there any known allergies? \_\_\_\_\_

Regular medication intake? \_\_\_\_\_

Previous operations (when, where)? \_\_\_\_\_

 **Previous births**

Date \_\_\_\_\_

Sex \_\_\_\_\_

Gestational age \_\_\_\_\_

Vaginal birth \_\_\_\_\_

Vacuum delivery/forceps \_\_\_\_\_

Caesarean section \_\_\_\_\_

Weight \_\_\_\_\_

Breastfed? \_\_\_\_\_

Problems in the postpartum period \_\_\_\_\_

Miscarriages/ectopic pregnancies  When \_\_\_\_\_

Abortions \_\_\_\_\_

Your gynecologist \_\_\_\_\_

Your attending midwife \_\_\_\_\_

Your attending pediatrician \_\_\_\_\_

 **Questions about the current pregnancy**

Last period \_\_\_\_\_

Due date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

During pregnancy, did you regularly:

smoke? No  Yes  Cigarettes/per day \_\_\_\_\_

consume drugs? No  Yes

pills? No  Yes

Do you want to breastfeed? No  Yes

 **Other comments**

I have the following comments and/or wishes for my birth: