JAKOBSTAD
PIETARSAARI
Social- och hälsovårdsverket
Sosiaali- ja terveysvirasto

PREPARATORY INFORMATION TO RÅDGIVNING/NEUVOLA

Dear expecting parents!
Please fill out the form and bring in to the rådgivning/neuvola

Name	Identity number
Address	Mother tongue
Phone (home, work)	E-mail
Occupation, (day work/shift work)	Employer
Contact person/partner	Identity number
Address (if other than above)	Mother tongue
Phone (home, work)	Occupation, employer

Marital status: ☐ Marriage ☐ Cohabitation ☐ Other

Previous pregnancies and births

Date	Previous pregnancy ceased week	Weeks of pregnancy	Sex F/M	Birth weight grams	Length of childbirth hours	Pregnancy, childbirth and puerperium	Length of breast-feeding months	Hospital

Children (name, age)

Health habits

I eat every day
☐ Breakfast ☐ Lunch ☐ Dinner ☐ Evening meal
Special diets

I use milk products every day
☐ Yes ☐ No

I exercise What kind of exercise?
☐ Regulary ☐ Irregulary ☐ Never

My partner´s health habits
☐ Breakfast ☐ Lunch ☐ Dinner ☐ Evening meal

My partner´s exercise What kind of exercise?
☐ Regulary ☐ Irregulary ☐ No

PLEASE TURN OVER

Latest menstrual period started	Length of menstrual cycle ____days Flow _____ days	Menstruation cycle regular ☐ irregular ☐	Latest PAPA (month/year)
Height and weight before pregnancy _____ cm _____ kg	Contraceptive before pregnancy?	Latest gynecological check-up	Previous infertility treatment ☐ no ☐ yes

Health conditions and diseases

Diseases and surgeries which may affect the pregnancy

☐ Diabetes	☐ Intestinal disease	☐ Neurological disease	☐ Rubella
☐ Hypertension	☐ Venous thrombosis	☐ Lung disease	☐ Chickenpox
☐ Coronary disease	☐ Thrombophilia	☐ Rheumatoid arthritis	☐ Urinary tract infection
☐ Asthma	☐ Thyroid disorder		☐ Incontinence
☐ Epilepsy	☐ Genital herpes	☐ Blood transfusion	☐ Condyloma
☐ Kidney disease	☐ Hepatitis C	☐ Eating disorder	☐ Gonorrhea
☐ Liver disease	☐ Hepatitis B	☐ Tumors	☐ Chlamydia
☐ Mental illness	☐ HIV	☐ Disability	☐ Operations/surgeries
☐ Allergy	☐ Circumcised	☐ Hormone treatments	_____
☐ Allergy to medicine	☐ Work-related risk	☐ Healthcare abroad	

Other:

Medication
Supplements/Vitamins
Partner´s health/diseases
Health status/diseases in the family that may affect the pregnancy

How would you describe your current health (status) _____
_____
_____
_____

What are your feelings about this pregnancy? _____
_____
_____

Do you or your partner have any fears about this pregnancy or childbirth?
_____
_____
_____

What are your expectations of the maternal health services? (prenatal care)
_____
_____
_____
_____