Collection Station
Stesen Kutipan

Pregnancy Questionnaire (To be completed by Obstetrician & Gynaecologist)

Policy No. : _____

Name of Assured / Expectant Mother :

NRIC No. :

PART A : General Details			
Number of Pregnancy / Fetus :	**Gravida** ☐☐ **Para** ☐☐ + ☐☐ **Age at First Pregnancy:** _____		
Natural Conception or otherwise (e.g. IVF) :			
Last Period (LMP) :		**Current Gestational Age :**	Weeks
Estimated Date of Delivery :		**Date of Last Follow-up :**	
Current Weight :	Kg	**Weight increased by kg :**	Kg

PART B : Details of Current and/or Previous Pregnancy

1. Is there any history of, or do you find any evidence of any disease or abnormality of:	**Yes**	**No**	If any of the questions answered as "Yes", identify question number and give details below
(a) Excessive or abnormal weight change which is not in proportion to pregnancy week	☐	☐	
(b) Pregnancy induced hypertension?	☐	☐	
(c) History of antepartum haemorrhage or PV bleeding?	☐	☐	
(d) Glycosuria or Gestational Diabetes Mellitus?	☐	☐	
(e) Pre-eclampsia / Eclampsia?	☐	☐	
(f) Ectopic or Molar pregnancy or gestational trophoblastic disease?	☐	☐	
(g) Proteinuria or any other abnormality in urine?	☐	☐	
(h) Significant anaemia (Hb < 8 mg/l) in pregnancy?	☐	☐	
(i) Miscarriage or spontaneous abortion? If yes, please state which trimester and was the cause established.	☐	☐	
(j) Premature delivery or evidence of premature uterine contraction?	☐	☐	
(k) Fetus abnormalities?	☐	☐	
(l) Any clotting disorder or placental abnormalities?	☐	☐	

	Yes	No	
(m) Fatty liver or acute fatty liver due to Pregnancy?	☐	☐	
(n) Cervical Incompetence?	☐	☐	
(o) Repeated Urinary Tract Infection?	☐	☐	
(p) Infection of the Uterus, Fibroid or Ovarian Cyst?	☐	☐	
(q) Thrombosis of disseminated, Intravascular coagulation or Amniotic fluid embolism?	☐	☐	
(r) Hospitalization during current pregnancy?	☐	☐	
(s) Any relevant medical history or congenital or genetic disorder which may impact the current pregnancy?	☐	☐	
(t) Any previous pregnancy complications or abnormities not mentioned above?	☐	☐	
2. Has the Expectant Mother been found to have the following?			
(a) Tested positive for Rubella or HIV?	☐	☐	
(b) Required to undergo chrionic villous sampling or amniocentesis or any screening e.g. triple test or genetic studies done?	☐	☐	
(c) Any medical conditions diagnosed prior to pregnancy?	☐	☐	
(d) Any other tests required or abnormalities detected not mentioned above?	☐	☐	

PART C : Fetal Assessment

Is there any abnormality noted on the following?	Yes	No	If any of the questions answered as "Yes", identify question number and give details below
(a) Fetal position or presentation?	☐	☐	
(b) Fetal development or Fetal size in relation to gestational age?	☐	☐	
(c) Fetal heart rate or Fetal movement?	☐	☐	
(d) Evidence of polyhydramnios or oligohydramnios?	☐	☐	
(e) Any other fetal abnormalies e.g. Intra uterine growth retardation?	☐	☐	
(f) Any blood screening, aminocentesis, triple test, genetic studies done?	☐	☐	
(g) Any other abnormalities, which are not mentioned above?	☐	☐	

PART D : Ultrasound

Please provide details for Ultrasound done

Gestation Age / Date of Ultrasound Done	Type of Ultrasound Done (2D/3D/4D)	Results

PART E : Other Investigations

Please provide details for other investigations carried out, e.g. Blood test, Scans, Urine microanalysis, screening of fetal trisomies, etc.

Date	Type of Investigations	Results

Note: Please attach copies of all investigation reports (including blood test, urine test, ultrasound etc)

Any additional information/comment?

This report has been prepared by:

Clinic's Official Stamp with Company Code

_____
Signature of Doctor

Name: _____

Date: _____ (MM/DD/YYYY)

Telephone No. _____