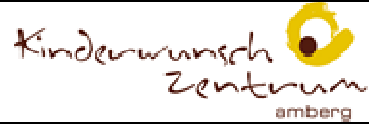
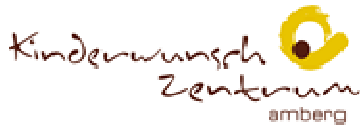


## Interne Formulare

Datei:M:\Interne Formulare\Kiwu\Mappen IVF\_ICSI Englisch\Rückmeldung Schwangerschaftsverlauf nach Kinderwunschbehandlung englisch Version 1.doc



## Kinderwunschzentrum



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## Pregnancy Feedback

**Please put this in your Motherpass and fill it out with the doctor after the birth or the end of the pregnancy and send it back to our office. Thank you!**

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

### Pregnancy through:

Insemination  Puncture  Cryo  Date of the Transfer/Insemination \_\_\_\_\_

**Abort** Date of the Abort \_\_\_\_\_

**EDD (due to conception):** \_\_\_\_\_

**Abortion** Date of the abortion \_\_\_\_\_

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> <b>Single Pregnancy</b> | amniotic cavity <input type="checkbox"/>                 | Heartbeat <input type="checkbox"/> |
| <input type="checkbox"/> <b>Twin</b>             | <b>Child 1:</b> amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
|  | <b>Child 2:</b> amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
| <input type="checkbox"/> <b>Triplet</b>          | <b>Child 1:</b> amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
|  | <b>Child 2:</b> amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |
|  | <b>Child 3:</b> amniotic cavity <input type="checkbox"/> | Heartbeat <input type="checkbox"/> |

### Complications in the pregnancy with allegation of the pregnancy week

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> none                            | <input type="checkbox"/> unknown                     | <input type="checkbox"/> early contractions        |
| <input type="checkbox"/> bleedings                       | <input type="checkbox"/> gestosis                    | <input type="checkbox"/> Hellp-Syndrome            |
| <input type="checkbox"/> imminent preterm birth          | <input type="checkbox"/> placenta praevia            | <input type="checkbox"/> early placenta detachment |
| <input type="checkbox"/> early rupture o.t.membranes     | <input type="checkbox"/> amniotic infection syndrome | <input type="checkbox"/> pregnancy diabetes        |
| <input type="checkbox"/> intrauterine growth retardation | <input type="checkbox"/> Other _____                 |  |

**Date of the birth** \_\_\_\_\_ **Pregnancy Week** \_\_\_\_\_

### Delivery of childbirth

spontaneous  vaginal (forceps, force cup)  C-section  pelvic presentation

	<b>Child 1</b>	<b>Child 2</b>	<b>Child 3</b>
<b>Gender</b>	<input type="checkbox"/> boy <input type="checkbox"/> girl	<input type="checkbox"/> boy <input type="checkbox"/> girl	<input type="checkbox"/> boy <input type="checkbox"/> girl
<b>Weight</b>	_____	_____	_____
<b>Size</b>	_____	_____	_____

<b>State of the child</b>	<input type="checkbox"/> healthy	<input type="checkbox"/> healthy	<input type="checkbox"/> healthy
	<input type="checkbox"/> intensive care	<input type="checkbox"/> intensive care	<input type="checkbox"/> intensive care
	<input type="checkbox"/> stillbirth	<input type="checkbox"/> stillbirth	<input type="checkbox"/> stillbirth

**Thank you for your cooperation! We wish you all the best! Your office team!**

MVZ Gynäkologisches Zentrum Amberg-Sulzbach GmbH, (HRB 5715-AG Amberg, GF Dr. med. Jürgen Krieg),  
Hauptsitz: Mariahilfbergweg 7, 92224 Amberg

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Datum: 08.10.19	Datum: 08.10.19	Datum:	