Kinderwunschzentrum

Dr. med. Jürgen Krieg
Emailfabrikstr. 15
92224 Amberg
Tel: 09621 769370
Fax: 09621 9601612
e-mail: info@dr-krieg.de

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 _____

EDD (due to conception): _____

☐ **Abort** Date of the Abort _____

☐ **Abortion** Date of the abortion _____

☐ **Single Pregnancy**		amniotic cavity ☐	Heartbeat ☐
☐ **Twin**	**Child 1:**	amniotic cavity ☐	Heartbeat ☐
	Child 2:	amniotic cavity ☐	Heartbeat ☐
☐ **Triplet**	**Child 1:**	amniotic cavity ☐	Heartbeat ☐
	Child 2:	amniotic cavity ☐	Heartbeat ☐
	Child 3:	amniotic cavtiy ☐	Heartbeat ☐

Complications in the pregnancy with allegation of the pregnancy week

☐ none	☐ unknown	☐ early contractions
☐ bleedings	☐ gestosis	☐ Hellp-Syndrome
☐ imminent preterm birth	☐ placenta praevia	☐ early placenta detachment
☐ early rupture o.t.membranes	☐ amniotic infection syndrome	☐ pregnancy diabetes
☐ intrauterine growth retardation	☐ Other _____	

Date of the birth _____ **Pregnancy Week** _____

Delivery of childbirth

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

	Child 1	**Child 2**	**Child 3**
Gender	☐ boy ☐ girl	☐ boy ☐ girl	☐ boy ☐ girl
Weight	_____	_____	_____
Size	_____	_____	_____
State of the child	☐ healthy ☐ intensive care ☐ stillbirth	☐ healthy ☐ intensive care ☐ stillbirth	☐ healthy ☐ intensive care ☐ stillbirth

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