Birth Record Admission form

The information in the form is archived and recorded in your electronic health record. According to the law, you have a right to review the information in your electronic health record. Information about pregnancy and birth is also submitted to the Medical Birth Registry. This is mandatory.

Please note: Remember to bring a copy of your Antenatal Health Card, blood typing result, ultrasound form and blood test results when you are going to the hospital.

PERSONAL DATA ABOUT THE CHILD'S MOTHER	
Surname:	Given name:
Middle name:	National identity number:
Address:	Postal code and post office/city:
Phone number:	Family doctor/GP:
Do you need an interpreter: ☐ No ☐ Yes, language:	Midwife attending the pregnancy:
Citizenship:	Health center where you will bring the infant for check-ups:
Marital status: ☐ Unmarried ☐ Married ☐ Co-habitant partner ☐ Separated ☐ Divorced ☐ Widow/widower	
Living arrangement: ☐ Alone ☐ Live together with spouse/partner ☐ Live together with others	
Education: ☐ Primary school ☐ High school ☐ College / University	
Are you and the child's father related genetically? ☐ No ☐ Yes Family relation:	
Occupation: ☐ Employed, full-time ☐ Employed, part-time ☐ Not employed ☐ Job seeker ☐ Pupil/student ☐ On social benefits	
Trade/Professional title(position):	
Do you consent to submitting information about your occupation to the Medical Birth Registry? ☐ No ☐ Yes	

PERSONAL DATA ABOUT THE CHILD'S FATHER/CO-MOTHER	
Surname:	Given name/middle name:
National identity number:	Phone number:
Address: ☐ Same address	Postal code and post office/city:
Citizenship:	
Marital status: ☐ Unmarried ☐ Married ☐ Co-habitant partner ☐ Separated ☐ Divorced ☐ Widow/widower	
Does the father/co-mother live with the child's mother? ☐ No ☐ Yes	Is the father/co-mother the next-of-kin?: ☐ No ☐ Yes
If you want to you can name another next-of-kin: Name, Relation, Birth date, Address and Phone number:	

Følsomhet GUL

THIS PREGNANCY

Height (cm):	Weight in kg at the start of the pregnancy:
Did you menstruate regularly before you became pregnant? ☐ No ☐ Yes Number of days in the cycle:	
First day of the last menstruation: ☐ Certain date ☐ Uncertain date	Due date established by ultrasound or IVF:
Is this an IVF pregnancy? ☐ No ☐ Yes	Number of fetuses:
Have you experienced bleeding during the pregnancy? ☐ No ☐ Yes, in week:	
Were you working at the start of the pregnancy? ☐ No ☐ Yes	
Were you on sick leave at the start of the pregnancy, if so, what percentage of sick leave? ☐ No ☐ Yes, …..%	
Does you occupation involve hazardous exposures? ☐ No ☐ Yes,……………………..	
Have you used hormonal contraception the last 6 months before to the pregnancy? ☐ No ☐ Yes	
Have you been vaccinated against or had rubella/measles? ☐ No ☐ Yes	

PREVIOUS PREGANCIES AND BIRTHS

Number of previous pregnancies:	Number of previous births (total):	Number of miscarriages before week 12:
Number of pregnancies outside the uterus:	Number of live births:	Number of miscarriages after week 12:
How many caesarean sections have you had?	Number of still births as of week 23 and later:	Number of self-determined abortions: Year of last self-determined abortion:

Please go page 4 to register more information about previous births.

SUBSTANCE USE

Do you consent to submitting information about any substance use to the Medical Birth Registry?
☐ No ☐ Yes

Before the pregnancy	No	Occasionally	Yes	
Did you smoke cigarettes before the pregnancy?	☐	☐	☐	Number per day:
Did you use “snus” before the pregnancy?	☐	☐	☐	
Did you drink alcohol before the pregnancy?	☐	☐	☐	
Did you use other substances before the pregnancy?	☐	☐	☐	Which:
Before week 12 (in the 1.trimester)				
Did you smoke cigarettes during the pregnancy, before week 12	☐	☐	☐	Number per day:
Did you use “snus” during the pregnancy, before week 12?	☐	☐	☐	
Did you drink alcohol during the pregnancy, before week 12?	☐	☐	☐	
Did you use other substances during the pregnancy, before week 12?	☐	☐	☐	Which:

Følsomhet GUL

After week 28 (in the 3.trimester)				
Did you smoke cigarettes during the pregnancy, after week 28?	☐	☐	☐	Number per day:
Did you use “snus” during the pregnancy, after week 28?	☐	☐	☐	
Did you drink alcohol during the pregnancy, after week 28?	☐	☐	☐	
Did you use other substances during the pregnancy, after week 28?	☐	☐	☐	Which:

PREVIOUS AND PRESENT ILLNESSES

☐ No diseases
☐ Gynecological conditions/surgery
☐ Mental illness
☐ Chronic kidney disease
☐ Recurrent urinary tract infections
☐ Chronic hypertension
☐ Cardiac disorders
☐ Diabetes I
☐ Diabetes II
☐ Lung disease
☐ Asthma
☐ Allergies
☐ History of epilepsy
☐ Current epilepsy
☐ Rheumatic arthritis
☐ Hepatitis B
☐ Hepatitis C
☐ Other:……………………………………

HEREDITARY ILLNESSES

Are there any hereditary illnesses in your family or your child's father's family? ☐ No ☐ Yes
If yes, please write which disease or genetic marker and who has it:

MEDICATIONS AND DIETARY SUPPLEMENTS

Have you used or are you using any medications during the pregnancy? ☐ No ☐ Yes
If yes, please write the name of medication and use:

Did you use multivitamins *before* the pregnancy? ☐ No ☐ Yes
Did you use multivitamins *during* the pregnancy? ☐ No ☐ Yes

Have you been taking folic acid before the pregnancy? ☐ No ☐ Yes
Have you been taking folic acid *during* the pregnancy? ☐ No ☐ Yes

Are there any medications you cannot take? ☐ No ☐ Yes
If yes, please write the name of medication and type of reaction:

Have you had opiate substitution treatment during the pregnancy? ☐ No ☐ Yes

MULTIDRUG-RESISTANT BACTERIA (MRSA, ESBL, VRE etc.)

Have you received treatment at a hospital or received dental treatment outside Norway in the last 12 months? ☐ No ☐ Yes

Have you stayed at a refugee camp in the last 12 months? ☐ No ☐ Yes

Have you had close physical contact with persons diagnosed with MRSA, ESBL or VRE in the last 12 months? ☐ No ☐ Yes

Have you been diagnosed with MRSA, ESBL or VRE in the past? ☐ No ☐ Yes

If you answered YES to any of these questions, please contact your family doctor as soon as possible. You will receive help to take any necessary tests and get adequate information. The test should be taken before admittance to the hospital to prevent multidrug-resistant bacteria from entering the hospital. For more information go to www.fhi.no.

Følsomhet GUL

PREVIOUS BIRTHS Live births and stillborn babies as of week 23.											
Year of birth	Place of birth	Mode of delivery (spontaneous/vacuum/forceps/ caesarean section/breech birth/other)	Complications (bleeding/perineal tear/other)	Sex	Completed weeks of gestation	Weight in grams	Did the child have any disfigurement?	Did you breastfeed?	The child is alive	Stillborn	The child is dead

Place: Date: Signature:

Please send this form to your hospital.
If something changes after you have sent in the form, please contact the hospital or send in a new one.

Thank you.

Følsomhet GUL