

INITIAL PREGNANCY QUESTIONNAIRE

REPORTER INFORMATION

| | | | | |
|--|------------------|---------------------|-------------------|-----------------|
| Patient <input type="checkbox"/> HCP* <input type="checkbox"/> <i>Specify Specialty</i> OB/GYN** <input type="checkbox"/> General Practitioner <input type="checkbox"/> Other <i>Specify</i> :..... <input type="checkbox"/> | HCP* Name | HCP* Address | HCP* Phone | HCP* Fax |
|--|------------------|---------------------|-------------------|-----------------|

* HCP: HealthCare Professional **OB/GYN: Obstetrician/Gynecologist

PATIENT INFORMATION

| | |
|--|---|
| Name (2 first letters) __ __ | First name |
| Date of birth __ __ __ __ __ __ __ __ <small>d d m m y y y y</small> | Weight __ __ __ kg Height __ __ __ cm |

| GARDASIL® Vaccine use during this pregnancy | | | Other Medication and/or Vaccine use during this pregnancy** | | | | | |
|---|-------------|------------|---|------------------------------|--------------------------|---------------|------------|----------------|
| Vaccination date | Dose number | Lot number | Product trade name | Date(s) of use (onset - end) | Lot number (for vaccine) | Strength (mg) | Daily dose | Reason for use |
| ___/___/___ | | | | ___/___/___ - ___/___/___ | | | | |
| ___/___/___ | | | | ___/___/___ - ___/___/___ | | | | |
| ___/___/___ | | | | ___/___/___ - ___/___/___ | | | | |

** Include all exposures (acute or chronic) that have occurred since Last Menstrual Period. Please continue on a blank page if necessary.

CURRENT PREGNANCY

| Date of onset of Last Menstrual Period: ___/___/___ | <input type="checkbox"/> Spontaneous pregnancy | <input type="checkbox"/> Medically Assisted Procreation | | |
|--|--|---|-----------------|----------|
| Estimated conception date: ___/___/___ | Estimated delivery date: ___/___/___ | | | |
| PRENATAL TESTING* | Date(s) of test | Results of test | Reason for test | Comments |
| Ultrasound | ___/___/___ | | | |
| Amniocentesis | ___/___/___ | | | |
| Alpha Fetoprotein test | ___/___/___ | | | |
| Serology tests (e.g. rubella, toxoplasmosis) | ___/___/___ | | | |
| Other (specify): | ___/___/___ | | | |

Please continue on a blank page if necessary or provide results of prenatal testing.

Significant Past Medical History – Specify:

Concurrent Medical Conditions – Specify:

OBSTETRIC HISTORY AND PREVIOUS PREGNANCY HISTORY

| Obstetric History | Number | Weeks from LMP** | | Yes/No/Unknown | If yes, describe |
|---|--------|------------------|---|----------------|------------------|
| Previous pregnancies | | N/A | Birth defect(s) in previous pregnancies? | | |
| Full-term deliveries | | N/A | | | |
| Pre-term births | | | Post-natal complications in previous pregnancies? | | |
| Early foetal death (≤ 20 weeks of gestation) | | | | | |
| <input type="checkbox"/> Spontaneous abortion | | | | | |
| <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Mole | | | | | |
| Late Foetal death (> 20 weeks of gestation) | | | | | |
| Termination <input type="checkbox"/> Voluntary <input type="checkbox"/> Medical | | | | | |
| Specify: | | | | | |

** LMP: Last Menstrual Period

Form completed by: **Date:** ___/___/___ **Signature:**

| | | | |
|----------------|--------------------|---------------------|--------------------|
| SPMSD Use Only | Received on: | ARISg number: | WAES number: |
|----------------|--------------------|---------------------|--------------------|

Please return this form to Sanofi Pasteur MSD, Pharmacovigilance department, Pregnancy Registry -
8, rue Jonas Salk – 69367 LYON Cedex 07 - FRANCE or fax to 0805.858.848