

**PREGNANCY OUTCOME QUESTIONNAIRE**

**REPORTER INFORMATION**

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

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

**PATIENT INFORMATION**

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

**PREGNANCY OUTCOME and OBSTETRIC INFORMATION – Please complete the information if applicable**

**Voluntary termination**  Please specify date: \_\_\_/\_\_\_/\_\_\_ or weeks from Last Menstrual Period |\_\_| |\_\_| } Specify reason: .....

**Early foetal death (≤ 20 weeks of gestation)**  Please specify date: \_\_\_/\_\_\_/\_\_\_ or weeks from Last Menstrual Period |\_\_| |\_\_| } .....

**Late foetal death (> 20 weeks of gestation)**  Please specify date: \_\_\_/\_\_\_/\_\_\_ or weeks from Last Menstrual Period |\_\_| |\_\_| } .....

**Were the products of conception examined?** Yes  No  If yes, describe: .....

**Was the foetus normal?** Yes  No  If no, describe: .....

**Complication during pregnancy:** Yes  No  If yes, describe: .....

**Complication during labor/delivery (induced/caesarian/foetal distress...):** Yes  No  If yes, describe: .....

**Diagnostic test during pregnancy:** Yes  No  If yes, describe: .....

**Infections or illness during pregnancy:** Yes  No  If yes, describe: .....

**LIVE-BORN INFANT \*If multiple birth, please photocopy and complete a form for each infant**

**New-born(s)\*:** 1  2  3  > 3  **Birth date** |\_\_| |\_\_| |\_\_| |\_\_| |\_\_| |\_\_| |\_\_|  
d d m m y y y y

**Gender:** Male  Female  **Initials** |\_\_| - |\_\_| |\_\_|  
1e first name letter 1e + 2e name letters

**Weight:** |\_\_|, |\_\_| |\_\_| |\_\_| kg **Height:** |\_\_| |\_\_| cm **Head circumference:** |\_\_| |\_\_| cm

**Apgar at 1 mn:** |\_\_| |\_\_| **at 5 mn:** |\_\_| |\_\_|

**Was the infant normal?** Yes  No

**If no, was there any congenital anomaly/birth defect?** Yes  No  Describe: .....

**Were there other post-natal complications or abnormalities?** Yes  No  If yes, describe: .....

Name of the infant's pediatrician	Address	Phone	Fax

**MEDICAL HISTORY INFORMATION**

**Any risk factors for adverse pregnancy outcome?**  
 Diabetes  Hypertension  Seizure disorder  Thyroid disorder  Hepatitis  Asthma  Allergy   
 Alcohol:  ... glasses/day Illicit drugs  Specify: .....  
 Tobacco:  ... cigarettes/day Other  Specify: .....

**Any history of congenital abnormality, genetic disorders in the family?** Yes  No  If yes, describe: .....

**Is there consanguinity with the partner?** Yes  No  If yes, specify the family relationship: .....

**OTHER MEDICATION and/or VACCINE USE DURING THIS PREGNANCY**

*Continue on a blank page if necessary*

Product trade name	Date(s) of use (onset - end)	Strength (mg)	Daily dose	Lot number (for vaccine)	Reason for use
	___/___/___ - ___/___/___				

Form completed by: ..... Date: \_\_\_/\_\_\_/\_\_\_ Signature: .....

SPMSD Use Only	Received on: .....	ARISg number: .....	WAES number: .....
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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