Birth Report (please tick as appropriate)

FERTILITY CENTER HAMBURG

☐ **Dr. R. Fischer** ☐ **Dr. K. Löbbecke** ☐ **Dr. T. Lindig**
☐ **T. Meyer** ☐

Therapy: ☐ IVF ☐ ICSI ☐ TESE ☐ Cryo-thaw-cycle ☐ Insemination ☐ Ovar. stimulation ☐ PBD ☐ PGD

Name _____ **First name** _____ **Date of birth** _____

Number of gestational sacs according to ultrasound in early pregnancy: _____

Tubal pregnancy: ☐ no ☐ yes
Miscarriage: ☐ no ☐ yes: Date: _____ or week of pregnancy: _____

Complications in pregnancy: ☐ no ☐ yes:
☐ Bleeding ☐ Gestational diabetes ☐ Premature rupture of membranes
☐ Vaginal infection ☐ Amniotic infection syndrome ☐ Fever ☐ Preeclampsia

☐ **Other:** _____

Delivery date: _____
Type of delivery: ☐ Vaginal ☐ Vacuum ☐ Forceps ☐ Caesarean Section

Complications during child birth: **(e.g. premature labour, preeclampsia, HELLP syndrome)**
☐ no ☐ yes: which: _____

Treatments: _____

Data of 1st child:
Sex: _____ Weight: _____ Length: _____
Birth deformities ☐ no ☐ yes:
which: _____
☐ Stillbirth
☐ Died shortly after birth, date: _____ Reason: _____

Data of 2nd child:
Sex: _____ Weight: _____ Length: _____
Birth deformities ☐ no ☐ yes:
which: _____
☐ Stillbirth
☐ Died shortly after birth, date: _____ Reason: _____

Data of 3rd child:
Sex: _____ Weight: _____ Length: _____
Birth deformities ☐ no ☐ yes:
which: _____
☐ Stillbirth
☐ Died shortly after birth, date: _____ Reason: _____

Ø Please add photocopies of your child's/children's U1 and U2