SERVIZIO SANITARIO REGIONALE EMILIA-ROMAGNA Azienda Unità Sanitaria Locale della Romagna Plasma Blood Program	Medical History Form	

TO THE TRANSFUSION CENTER/TRANSFUSION MEDICINE UNIT

- Surname and first name ………………………………………………………………...
- Date and place of birth ……………………………………………………………..
- Telephone number …………..………………………………………………………...
- Family doctor ……………….…………….…. Tel………………………
- Gynecologist ………………………….………………………. Tel ……………………..
- Midwife …... Tel……………………..

DATE…………………..

HOSPITAL……………………………..

• Current stage of pregnancy	Week……………………………………………………….. Day of last menstrual period…………………………………….. Expected date of delivery………………………………………
• Previous pregnancy	YES/SI ❑ N° …….when (year(s)) ………………….. NO ❑
• Previous childbirth, previous immunizing events (miscarriage, amniocentesis, villocentesis, etc.)	YES/SI ❑ N° …….when (year(s)) ………………….. NO ❑
• Anti-D immunoprophylaxis	YES/SI ❑ when (year and month) ………………….. NO ❑ DON'T KNOW/NON SO ❑
• Have you ever had a blood transfusion?	YES/SI ❑ when (year(s)) …………………… NO ❑
• Do you intend to give birth in an outpatient facility?	YES/SI ❑ NO ❑

Signature

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