

Initial Pregnancy Questionnaire - GARDASIL® [human papillomavirus (Types 6, 11, 16, 18) Recombinant Vaccine]

Merck & Co., Inc. is committed to the CONFIDENTIAL collection of patient information. In order to allow for the collection of pregnancy outcome data, minimize duplicate reporting, and prevent loss to follow-up, please COMPLETE ALL SECTIONS below. Please correct any inaccurate pre-filled data.

Physician Information

Name	Address	Phone	Fax	Office contact
Primary Care Provider				
OB/GYN				
Other (Specify)				

Patient Information

Patient Name:		Date of Birth:	____/____/____	
Office Chart Number:		Phone Number:		
Address:	City		State	Zip Code
Race/ethnicity:	<input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Multiracial			

Significant Past Medical History- Specify _____

Concurrent Medical Conditions- Specify _____

GARDASIL® Vaccine Use This Pregnancy

Other Medication Use This Pregnancy

Date(s) of use	Dose #	Lot Number	Name	Date(s) of use	Strength (eg. 5 mg)	Frequency	Reason for Use

*Include all exposures that have occurred since last menstrual period (LMP). Please continue on a blank page if necessary.

Current Pregnancy			Estimated conception date (if known) ____/____/____	
			Date of last menstrual period ____/____/____	Estimated delivery date ____/____/____
PRENATAL TESTING	Date(s) of test	Results of test	Reason for test	Comments
Ultrasound				
Amniocentesis				
MSAFP				
Other _____				

Obstetric History	Number	Weeks from LMP		Yes / No / Unknown	If yes, describe
Previous pregnancies		NA	Birth defect(s) in previous pregnancies?		
Full term deliveries					
Pre-term deliveries					
Spontaneous abortions (miscarriages)			Infant complications in previous pregnancies?		
Elective terminations					
Fetal deaths (stillbirths)					

Questionnaire was completed by: _____ Date: _____

Merck Use Only	WAES Number
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Return form to: Merck Pregnancy Registries, Worldwide Product Safety/Clinical Risk Management & Safety Surveillance, P.O. Box 4, WP97A-285, West Point, PA 19486 or Fax to: (215) 993-1220

Outcome Pregnancy Questionnaire - GARDASIL® [human papillomavirus (Types 6, 11, 16, 18) Recombinant Vaccine]

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Patient name: _____

Pregnancy Outcome (If multiple birth, please photocopy and complete a form for each infant)

Liveborn infant: Birthdate ___/___/___ Sex ___ Weight ___ Length ___ Apgar score ___/___
 Weeks from LMP _____ Head circumference _____ Infant name _____

Was the infant normal? yes no If no, describe _____

Were there congenital anomalies? no yes If so, describe _____

Were there other complications or abnormalities? no yes If so, describe _____

Elective termination **Spontaneous abortion** (≤ 20 weeks) **Fetal death/stillbirth** (> 20 weeks)

Date ___/___/___ Weeks from LMP _____

Were the products of conception examined? unknown no yes Describe _____

Was the fetus normal? unknown yes no If no, describe _____

Obstetric Information

yes no Complication during pregnancy, specify _____

yes no Complication during labor/delivery, specify _____

yes no Diagnostic test during pregnancy. If yes, dates and test results: _____

yes no Infections or illnesses during pregnancy, specify _____

Medical History Information

yes no Concurrent medical conditions, specify _____

Are you aware of any other information that would inform the outcome of this pregnancy (family history, smoking etc)?

Other Medication Used During This Pregnancy

Name of medication	Date(s) of use	Strength (eg. 5 mg)	Frequency	Reason for Use

Pediatrician Name	Address	Phone	Fax	Office contact

Questionnaire was completed by: _____ Date: _____

Merck Use Only	WAES Number _____
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