MERCK
Research Laboratories

Pr Proprietary

Initial Pregnancy Questionnaire

GARDASIL®9 [human papillomavirus 9-valent vaccine, recombinant]

Merck 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.

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

Patient Information

Patient Name:		**Date of Birth:**	
Office Chart Number:		**Phone Number:**	
Address:	City	State	Zip Code
Race/ethnicity:	❑ Caucasian ❑ Black ❑ Asian ❑ Hispanic ❑ Native American ❑ Multiracial		

Significant Past Medical History- Specify_____

_____

Concurrent Medical Conditions- Specify_____

_____

GARDASIL®9 Vaccine Use This Pregnancy

Date(s) of use	Dose #	Lot Number

Other Medication Use This Pregnancy

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/Unk	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 **MARRS #** _____

Return form to: Merck Pregnancy Registries, Clinical Safety and Risk Management, P.O. Box 4, WP97A-285, West Point, PA 19486 or Fax to: (215) 993-1220

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Outcome Pregnancy Questionnaire

GARDASIL®9 [human papillomavirus 9-valent vaccine, recombinant]

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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:** _____

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