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Initial Pregnancy Questionnaire - MAXALT® (rizatriptan benzoate)

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 information.

Physician Information

Name	Address	Phone	Fax	Office Contact
Primary Care Provider				
OB/GYN				
Neurologist				

Patient Information

Office Chart Number: _____ Date of birth ____/____/____

Patient name (last, first, middle) _____

Address _____

City _____ State_____ Zip Code _____

Race/ethnicity: ❑ Caucasian ❑ Black ❑ Asian ❑ Hispanic ❑ Native American ❑ Multiracial

MAXALT® Use This Pregnancy

Date(s) of use	Strength (mg)	Number of doses taken	Maxalt® Tablet or Maxalt MLT™ ?

Other Medication Use This Pregnancy

Name	Date(s) of use	Strength (eg. 5 mg)	Number of doses taken

Current Pregnancy

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 _____				

Pregnancy History *(may attach copy of ACOG Antepartum Record [Form A]or equivalent from patient's chart)*

Number of previous pregnancies _____ full-term deliveries _____ pre-term births _____

Did a birth defect occur in any previous pregnancy? ❑ yes ❑ no ❑ unknown

If yes, specify _____

Did a stillbirth or miscarriage occur in any previous pregnancy? ❑ yes ❑ no ❑ unknown

If yes, in what week of pregnancy did the stillbirth or miscarriage occur? _____

Questionnaire was completed by:_____ **Date:** _____

Merck Use Only **WAES Number** _____

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

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Outcome Pregnancy Questionnaire - MAXALT® (rizatriptan benzoate)

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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 _____ Weeks from LMP _____
Was the infant normal? ❑ yes ❑ no
Were there congenital anomalies? If so, describe _____
Were there other complications or abnormalities? If so, describe _____
_____

↳❑ Elective termination ❑ Spontaneous abortion (< 20 weeks) ❑ Fetal death/stillbirth (≥ 20 weeks)
Date ____/____/____ Weeks from LMP _____
Were the products of conception examined? ❑ yes ❑ no ❑ unknown
Was the fetus normal? ❑ yes ❑ no ❑ unknown
If no, describe _____

Obstetric Information

❑yes ❑no Complication during pregnancy, specify _____
❑yes ❑no Complication during labor/delivery, specify _____
❑yes ❑no Diagnostic tests during pregnancy. If yes, dates and test results:_____
_____
❑yes ❑no Infections or illnesses during pregnancy (other than migraine), specify _____
❑yes ❑no Concurrent medical conditions, specify _____
_____

MAXALT® Use This Pregnancy

Date(s) of use	Strength (mg)	Number of doses taken	Maxalt® Tablet or Maxalt MLT™ ?

Other Medication Use This Pregnancy

Name	Date(s) of use	Strength (eg. 5 mg)	Number of doses taken

↳ Describe any additional information that might help in interpreting the outcome of this pregnancy:
_____
_____
_____

Pediatrician Name	Address	Phone	Fax	Office contact

Questionnaire was completed by:_____ **Date:** _____

Merck Use Only **WAES Number** _____

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