

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

Other Medication Use This Pregnancy

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

Other Medication Use This Pregnancy

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