

Initial Pregnancy Questionnaire - SINGULAIR® (montelukast sodium)

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				
Pulmonologist				
Allergist/Immunologist				

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

SINGULAIR® Use This Pregnancy

Other Medication Use This Pregnancy

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

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 - SINGULAIR® (montelukast sodium)

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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 test during pregnancy. If yes, dates and test results: _____

yes no Infections or illnesses during pregnancy, specify _____

yes no Concurrent medical conditions, specify _____

SINGULAIR® use during this pregnancy

Other medication use during this pregnancy

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

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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