

Initial Pregnancy Questionnaire

Pregnancy Registry for VARICELLA ZOSTER VIRUS CONTAINING VACCINES

VACCINE ADMINISTERED: Varivax® ProQuad® Zostavax®

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				

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

Varicella Zoster Virus (VZV) containing vaccine used in this pregnancy/Other medication use in this pregnancy

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

Patient was vaccinated at: private MD office/hospital, public health clinic/hospital, military clinic, other/unknown _____

Was patient tested for varicella antibodies before vaccination with VZV containing vaccine

yes no unknown

If yes, specify date: _____ and results: positive negative uncertain

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? _____

Maternal Adverse Event

yes no unknown Local reaction at vaccination site? onset date ____/____/____

yes no unknown Varicella (chickenpox) symptoms post vaccination? onset date ____/____/____

yes no unknown Herpes zoster (shingles) symptoms post vaccination? onset date ____/____/____

If yes to any of the above, please describe: _____

Questionnaire was completed by: _____

Date: _____

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Outcome Pregnancy Questionnaire

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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 _____

Other Medication Used During This Pregnancy

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

Infant Adverse Event

yes no Any feature of congenital varicella zoster syndrome (cutaneous scars, limb hypoplasia, eye and CNS malformations, neurologic deficits)? If yes, describe _____

Pediatrician Name	Address	Phone	Fax	Office contact

Questionnaire was completed by: _____ Date: _____

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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**