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Initial Pregnancy Questionnaire – (check one)

☐ **JANUVIA® (sitagliptin phosphate)** ☐ **JANUMET® (sitagliptin phosphate/metformin hydrochloride)**

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				
Diabetelogist				

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

JANUVIA® or JANUMET® Use This Pregnancy

Date(s) of use		Strength (mg)	Number of doses taken
From:	To:		

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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Pregnancy Outcome Questionnaire – (check one)

□JANUVIA® (sitagliptin phosphate) **□JANUMET® (sitagliptin phosphate/metformin hydrochloride)**

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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 _____
_____

JANUVIA® or JANUMET® 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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