GlaxoSmithKline

Varilrix Pregnancy Registry Registration Form

Patient ID or initials:	GSK OCEANS Case No.:

Mother's Relevant Medical/Family History

Mother's Date of Birth ☐☐☐☐☐☐ (M M M DD YR) or age ☐☐ years

Estimated Date of Conception (if known) ☐☐☐☐☐☐ (M M M DD YR)

Date of last menstrual period ☐☐☐☐☐☐ (M M M DD YR)

Estimated Date of Delivery ☐☐☐☐☐☐ (M M M DD YR)

Race □ White □ Black □ Asian □ Hispanic □ Other or mixed _____

Was the mother using contraception?

☐ Yes, specify _____ ☐ No

Type of conception

☐ Normal ☐ IVF (in vitro fertilization) ☐ Other assisted fertility methods (e.g. drugs)

Is there evidence of a defect from prenatal testing: ☐ Yes ☐ No
Indicate tests performed and date(s) done:

Prenatal Testing Performed			
Test	**Date of Test**	**Reason for Test**	**Results of Test**
☐ ultrasound			
☐ amniocentesis			
☐ (MS)AFP			
☐ other_____			

Number of previous pregnancies
If applicable, record numbers in categories below:
Outcomes:

☐ Normal births ☐ Pre-term births ☐ Stillbirths

☐ Spontaneous abortion(s) -- <20 weeks gestation ☐ Children born with defects

☐ Fetal demise (≥20 weeks gestation) ☐ Elective termination(s)

Record details of pre-term births (gestational age at birth, post-natal complications) or children born with defects

_____

_____

_____

_____

Describe any maternal history or complications of previous pregnancies which may have an impact on the outcome of this pregnancy

_____

_____

_____

_____

Drug/Vaccine Exposures

Drug Name	Route or formulation	Dose	Start Date	Stop Date	Ongoing Y/N	Indication
Cervarix	**IM**				**□Y □N**	
					□Y □N	
					□Y □N	
					□Y □N	
					□Y □N	
					□Y □N	

Father's Relevant Medical/Family History

Describe any paternal history which may have an impact on the outcome of this pregnancy

_____

_____

_____

_____

_____

REPORTER INFORMATION

Name: _____

Degree: ☐ MD ☐ DO ☐ RN ☐ Other _____

Specialty: _____

Address:

_____

City and State: _____ Zip code:

_____

Telephone no: | | | | | | | | | | |

Fax no: | | | | | | | | | | |

Reporter's signature: _____ Date: | | | | | | | | |

M M M DD YR

RETURN FORM TO GLAXOSMITHKLINE

Call 0800 221441 GlaxoSmithKline UK Stockley Park West, Uxbridge, Middlesex, UB11 1BT Telephone: +44 (0)800 221 441 Fax: +44 (0)208 990 4328 Medical Information e-mail: customercontactuk@gsk.com	OR	GlaxoSmithKline Biologicals Biologicals Clinical Safety and Pharmacovigilance (Central Safety Office) Rue de l'Institut 89B-1330 Rixensart, Belgium Fax: 32 2 656 8009 or 32 2 656 5116 Email: safety-vac ww/pharmbio/gsk@gsk