Women's and Children's Physicians of Naples

PRENATAL QUESTIONNAIRE

Parent Information

Mother:

Name: _____
Address: _____
_____
Phone Number: _____
Occupation: _____
Age: _____
Medical Problems: _____
_____
_____
Current Medications: _____
_____
Allergies: _____

Father:

Name: _____
Address: _____
_____
Phone Number: _____
Occupation: _____
Age: _____
Medical Problems: _____
_____
_____
Current Medications: _____
_____
Allergies: _____

Family History

Has the baby's mother or father or anyone in either family ever had any of the following? If yes, then please circle.

-Cancer before age 50
-Chromosomal abnormalities
-Cleft lip or palate
-Cystic Fibrosis
-Diabetes
-Down Syndrome
-Epilepsy (seizures)
-Hearing loss/deafness
-Heart attack before age 40
-Heart defect
-Hemophilia
-Huntington's Disease
-Infant that died prematurely
-Kidney disease
-Limb defect(s)
-Mental retardation
-Muscular Dystrophy
-Neural tube defect (e.g. spina bifida)
-Neurofibromatosis
-Phenylketonuria
-Sickle cell anemia
-Tay Sach's Disease
-Thalassemia
-Vision loss/blindness

Pregnancy History

Have you received prenatal care? Yes / No
Name of obstetrician: _____
Estimated due date: _____
Desires regarding feeding/nutrition: Breast or Bottle

During the pregnancy, have you had any of the following?

uterine cramping	Yes / No
vaginal leakage of fluid	Yes / No
vaginal bleeding (spotting)	Yes / No
infections, rashes, or other illness	Yes / No
X-rays, hospitalizations, or surgery	Yes / No
cigarettes, alcoholic beverages, or "street drugs"	Yes / No
ultrasound	Yes / No
occupational, chemical, or other exposure	Yes / No
prescription or non-prescription medication	Yes / No
prenatal vitamins	Yes / No
other problems (If yes, then please specify and elaborate.)	Yes / No

_____
_____

Questions you may have? _____
_____

How did you hear about our office? _____ Name of health insurance: _____

Form completed by: _____ Date: _____