

Pre-Natal Questionnaire.

Name: _____

Marital Status: _____

If Married, Maiden Name: _____

Occupation: _____

Baby's Father's Name: _____

Father's Date of Birth: _____

Father's Occupation: _____

For Expecting Mother

First Day of Your Last Normal Menstrual Period: _____

Are You Sure of the Date? _____

Have You Been Pregnant Before? If Yes, How Many Times? _____

Did you deliver all pregnancies? If not please specify if it was an abortion, miscarriage or ectopic pregnancy.

Expecting Mother's History

Answer Yes or No to the following questions please:

Operations?

Blood transfusions?

High blood pressure, circulation difficulties or heart abnormalities?

Diabetes?

Epilepsy or other seizure disorders?

Kidney problems?

Sexually transmitted diseases?

Chicken Pox? Or Chicken Pox vaccine?

Psychiatric history or previous post partum depression?

Were you taking birth control ?

Are you taking any medications right now?

Do you have any allergies?

Do you smoke?

Any alcohol use during pregnancy?

Any street drug use (cocaine, marijuana etc) in the past or present?

Family History From Both Parents

Please answer yes or no, if answer is yes; please specify which side of the family and which family member:

Diabetes?

Hereditary Diseases?

High Blood Pressure?

Any malformation with other births? (ie extra fingers or toes etc)

Any Twins?

If you have any questions regarding the above, please bring them forward when you come to the office for the first pre-natal visit. Please either fax this completed questionnaire to 259-3355 or bring it to your appointment with you. Please arrive **10 min** early.