PRENATAL QUESTIONNAIRE

First, print out this form. Fill it out. Bring it with you to our office.

Date: _____

Mother's Name: Occupation:

Father's Name: Occupation:

How did you hear about us?

Due Date: DD MM YYYY Week's Pregnant:

Name of Obstetrician: Hospital where the delivery is scheduled:

Mother's age at child's birth: Is this a ☐ single/multiple birth pregnancy (list number of fetuses)

What type of delivery is scheduled (check): ☐ Vaginal ☐ C-Section

Have you had a miscarriage or abortion? ☐ Yes ☐ No If yes, date of miscarriage or abortion

Maternal illness during pregnancy or early labor ? ☐ Yes ☐ No If yes, list the illness?

Maternal use of medications other than vitamins ☐ Yes ☐ No If "yes", list the medications?

Do you have other children? ☐ Yes ☐ No If yes, list their name & ages

Any problems on prenatal Ultrasound? ☐ Yes ☐ No If yes, Explain

Maternal use of tobacco/alcohol during pregnancy? ☐ Yes ☐ No If yes, Explain

List any significant chronic illnesses in the family that the parents or other children have had:

Is there a smoker in the household? ☐ Yes ☐ No If yes, Explain

Are you planning to ☐ breastfeed or ☐ bottle-feed?