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WILSON PEDIATRICS

Prenatal Questionnaire

Mother to Be: _____Age: _____

Important Past, Present Medical/Surgical Problems:_____

Medicines/Prescription Drugs used frequently:_____

Occupation:_____

Prenatal History:

Number of Pregnancies: _____ Living Children: _____ Premature Delivery:_____

Miscarriages/Abortions: _____ Problems at delivery?_____

Father to Be:_____Age_____

Prior Children or Step Children? Yes: ◯ No: ◯ Occupation:_____

Medicines/Prescription Drugs used frequently:_____

Important Past, Present Medical/Surgical Problems:_____

Other Children:

Name:_____ D.O.B. _____

Medical History:_____

Name:_____ D.O.B. _____

Medical History:_____

Was either parent sick at conception? Yes: ◯ No: ◯ Use of fertility drugs by either parent? Yes: ◯ No: ◯

Either parent taking any type of medicine/prescription drugs at conception?_____

Illness/Problems (including bleeding, infection, rupture of membranes, hospitalizations, etc.) during pregnancy?

_____

Use of Alcohol/Tobacco/Other?_____ Exposure to infections? _____

Sonogram results:_____

Sex of baby: M ☐ F ☐ Unknown ☐

Due Date: _____ Name of Obstetrician:_____

Total weight gain: _____Feeding: Breast ☐ Bottle ☐

Anticipated method of delivery: Vaginal ☐ C- Section ☐

Delivery will take place at:

North Collier Hospital ☐ Other_____

Will you be attending prenatal classes? ☐ Class Type:_____

Newborn Questions:_____

_____

Adoption History if Applicable:_____