Chantilly Pediatrics

Infant, Child and Adolescents Medicine

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Prenatal Questionnaire

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

Today's Date: ___________

Mother's Name ___________________________ occupation: _____________________
Father's Name ___________________________ occupation: _____________________

How did you hear about us? ____
Due Date: ______________
Week's Pregnant: _____________
Name of obstetrician: ____
Hospital where the delivery is scheduled: _________________________________

Mother's age at child's birth _______
Is this a single ________ or multiple birth pregnancy ___________ (list number of fetuses)
Do you have other children? If "yes", list names and ages: ___________________________________
____

Have you had a miscarriage or abortion? Yes / no
Maternal illness during pregnancy or early labor? If "yes", list:___________________________________
Maternal use of medications other than vitamins If "yes", list:____________________________________
What type of delivery is scheduled (check) : ___ Vaginal ___ Caesarian

Any problems on prenatal Ultrasound? If "yes", list: ____
Maternal use of tobacco/alcohol during pregnancy? Yes / No
List any significant chronic illnesses in the family that the parents or other children have had:
____

Is there a smoker in the household? ____

Are you planning to breastfeed _____ or bottle-feed____? (check)