Prenatal Questionnaire

Mother's Name: _____ Date of Birth: _____
Father's Name: _____ Date of Birth: _____
Home Address: _____ Telephone #: _____
_____

Mother's Employer: _____ Telephone #: _____
Father's Employer: _____ Telephone #: _____

Expected Due Date: _____ Vaginal / Scheduled C-Section
Hospital: _____ OB/GYN: _____

Mom & Baby's Insurance: _____
Baby's Sex, If Known: _____
Are You Planning On Circumcising? _____
Do You Plan On Breast Feeding or Bottle Feeding? _____
If Bottle Feeding, Which Type pf Formula? _____

List Any Complications Throughout Pregnancy (i.e. excess vomiting, high blood pressure, high blood sugar, etc.):

_____
_____
_____
_____

List Any Infections During Pregnancy:

_____
_____
_____
_____

List Any Medications Used During Pregnancy (include prenatal vitamins, OTC medications, herbal supplements, etc.):

_____
_____
_____

Have You Used Any of the Following During Pregnancy?

Alcohol? Yes / No If yes, how much? _____
Tobacco? Yes / No If yes, how much? _____
Illicit Drugs? Yes / No If yes, how much? _____

List All Other Pregnancies and Outcomes (include miscarriages, still births, types of deliveries, etc.):

_____
_____
_____
_____

List Names, Sex, and Ages of Other Siblings (include step children):

_____
_____
_____
_____

Mother's Past Medical History:

_____
_____
_____
_____

Please List Any Significant Family Medical History (i.e. diabetes, cancer, heart disease, kidney disease, mental illnesses, etc.):

_____
_____
_____
_____

Smokers in the Family, If Any: _____

Pets, If Any, and Types:

_____
_____

Whom May We Thank for Referring You?

_____