

Berkeley Pediatric Medical Group
PRENATAL VISIT INTAKE

Today's Date: _____

Parent Name: _____

Age: _____

Gender: _____

Occupation/ Employer: _____

Anticipated length of time off after infant birth: Parent

Name: _____

Age: _____

Gender: _____

Occupation/ Employer: _____

Anticipated length of time off after infant birth: _____

Marital Status: married divorced single

Pregnancy History

- What is your estimated due date? _____

- Is this your first pregnancy? _____

yes no

- If no, any problems with your previous pregnancies? _____

yes no

- Any prior miscarriages or terminations? _____

yes no

- Was IVF used for conception? _____

yes no

- Have you had any problems with this pregnancy? _____

yes no

If yes please explain: _____

- Did you have an ultrasound at/or around 20 weeks gestation? _____

yes no

- Were there any problems noted with this ultrasound? _____

yes no unsure

- Do you know the sex of your baby? _____

boy girl unsure

- If you have a boy, do you want a circumcision? _____

yes no unsure

- Where are you planning on delivering your baby? _____

Alta Bates UCSF CPMC Other _____

Who is your OBGYN or midwife? _____

Postpartum:

- How do you plan to feed your newborn? Breastfeed Formula unsure

Family Social History:

- Do you have other children? _____

yes no

- Do you have a pool or hot tub? _____

yes no

- Are there smokers in your household? _____

yes no

- Do you have guns in your home? _____

yes no

- Do you have pets in your home? _____

Dogs Cats Other _____

- Is your home single or multiple stories? _____

yes no

- Is your home built before 1980? _____

yes no

- If yes, is there peeling paint or ongoing renovations? _____

yes no

Biological Mother's Health:

- Any health problems? yes no
- Any prior diagnosis or treatment for depression, anxiety or other mental health concerns? yes no
- Any history of a positive PPD or history of tuberculosis? yes no
- If yes please explain: _____

Biological Father's Health:

- Do you have any health problems? yes no
- Any prior diagnosis or treatment for depression, anxiety or other mental health concerns? yes no
- Any history of a positive PPD or history of tuberculosis? yes no
- If yes please explain: _____

Family Medical history (if yes, please indicate if maternal/ paternal and degree of family member):

- congenital heart condition: yes no
- lung problems: yes no
- seizures: yes no
- learning disability: yes no
- developmental delay: yes no
- congenital hip problems: yes no
- jaundice yes no

Have you / your partners / household members had Tdap and flu vaccinations? yes no

Would you like to have a Tdap vaccine at today's visit? yes no

Would you like to receive a Flu vaccine at today's visit? yes no

Do you plan to vaccinate your child according to the recommended schedule? yes no

Do you plan to receive routine newborn hospital care (erythromycin eye ointment, Hep B vaccine, Vit K injection) yes no

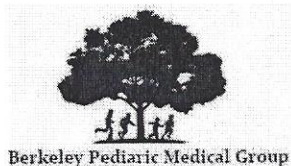
Are there any other specific questions we can help address?

no yes

How did you hear about our practice?

- Website
- Internet Search
- Yelp
- Magazine
- Mail/ Print
- Friend / Family Referral
- Physician Referral
- Alta Bates Information Session
- Other

Reviewed by: _____



FAMILY HISTORY QUESTIONNAIRE

Only one copy of this page needs to be filled out per family. We will scan a copy in each child's chart.

Date: _____

Person Filling out this form: _____ Relationship to child: _____

PATIENT INFORMATION:

Child #1: _____ DOB: _____ Male Female Other: _____

Child #2: _____ DOB: _____ Male Female Other: _____

Child #3: _____ DOB: _____ Male Female Other: _____

Child #4: _____ DOB: _____ Male Female Other: _____

FAMILY HISTORY: PLEASE CHECK IF CHILD'S BIOLOGICAL RELATIVES HAVE ANY OF THESE CONDITIONS. USE THE BOTTOM OF THIS FORM IF EXTRA SPACE IS NEEDED.

	Y	N	Who was affected?	Explain
1. Allergies (Asthma, Eczema, Hay Fever, Food Allergies)				
2. Blood disorders (Bleeding, Clotting, Sickle Cell, Anemia)				
3. Bone/ Joint/ Rheumatic disorders (including hip problems in infants)				
4. Cancer (before 55 years old)				
5. High Cholesterol				
6. Diabetes (before 55 years old)				
7. Eye problems (blindness, lazy eye, crossing eyes)				
8. Ear problems (childhood hearing loss, hearing impairment, or hearing aid)				
9. Gastrointestinal Disorders (Celiac, Crohns, Ulcerative Colitis, GERD)				
10. Genetic disorders or Birth Defects (Cystic Fibrosis, Downs syndrome, Cleft Lip, Club Foot, Hip Dysplasia)				
11. Heart disease (Heart Attacks, arrhythmia) <65 years old for female, <55 years old for males				
12. Hypertension/ high blood pressure				
13. Infectious diseases or problems with immune system (HIV, Tb, Immunodeficiency)				
14. Kidney problems				
15. Nervous system disorders (migraines, seizures, epilepsy)				
16. Obesity				
17. Psychiatric conditions (Depression, Anxiety, ADHD)				
18. Thyroid problems				
19. Alcoholism or Drug dependence				
20. Regular Smoker				
21. Bed Wetting (older than 10 years of age)				
22. Other				

Reviewed By: _____