Berkeley Pediaric 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: _____

Berkeley Pediatric Medical Group

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:_____