TOWN CENTER PEDIATRICS

Prenatal consultation

Appointment with Dr: ______________________ Baby's Due Date: ______________________
Parent Name: ______________________ Parent Name: ______________________
Home Address: ______________________ Telephone #: ______________________
______________________ Referred By: ______________________
Insurance Information: ______________________
OB/GYN: ______________ Hospital: ______________ Marital Status: S / M / D
Do you expect to have a C-Section?: Yes / No Is the baby's sex known?: Yes / No ________

Maternal History:

Age: ________ Blood Type: ________ Which pregnancy (#) is this for you: ________
# of miscarriage: ________ # of Live Births: ________ Did all previous babies come tom time: Y / N
Previous babies were Vaginal or C-Section births (Circle One) Were there delivery complications? Y / N
How much did the largest baby weigh? ________ How much did the smallest baby weigh? ________

Maternal illness during pregnancy (Check any that apply)

_____ High Blood Pressure _____ Anemia _____ Sexually Transmitted Disease
_____ Dibetes _____ Severe Vomiting _____ Swollen Ankles _____ Group B Strep
_____ Protein in Urine _____ German Measles _____ Urinary Infection _____ Excessive Wt Gain
Other: ______________________

Maternal medications taken during this pregnancy (Check all that apply)

_____ Vitamins _____ For Swelling _____To sleep
_____ Iron _____ For Infection _____Asprin
_____ Hormones _____ High Blood Pressure _____For nausea
Other: ______________________

During this pregnancy did you: (Check all that apply)

_____ Smoke _____ Drink Alcohol _____IV drug use _____ Cocaine
_____ Have X-Rays Other: ______________________

Family History: (Of the expected baby)

Name: **Date of Birth:** **Birthplace:** **Health Status:**
Parent: ______________________
Parent: ______________________
Siblings: ______________________
(of the ______________________
New baby) ______________________
Religious Affiliation (optional): ______________________

Have any of this child's blood relatives had: (Check any that apply)

_____ Severe Anemia _____ Asthma _____ Short stature _____ Bleeding disorder
_____ Tuberculosis _____ Birth deformity _____ Mental disability _____ Allergy/Hay fever
_____ Heart disease _____ Inherited diseases _____ Emotional illness _____ Bone/Joint disease
_____ Digestive disease _____ Cancer _____ Diabetes _____ Neurologic disease
_____ Thyroid disease _____ Kidney disease _____ Eye or Ear disease _____ Obesity
_____ Cystic fibrosis _____ Down's Syndrome _____ Convulsions/Epilepsy
Other: ______________________

Prenatal preparation and plan:

Prenatal classes: Yes or No Who Attended: ______________________
Books / Videos / Other educational materials used to prepare for birth and child care:
____
____
Family in delivery room Y / N Circumcision Y / N Breast feeding Y / N Formula Feeding Y / N
Who will be the Primary Care giver for this child? ______________________