PAPAGO BUTTES PEDIATRICS
A Division of Arbor Medical Partners

DATE: _____

HOME # _____
CELL PHONE# _____

WORK # _____

PRENATAL HISTORY FORM

NOTE: This questionnaire is to help your Pediatrician assess the future health of your unborn baby, and in certain circumstances it can be extremely important.

How were you referred to our office: _____

Mother's Name: _____

Father's Name: _____

Home Address: _____

Year of Mother's birth: _____ **Year of Father's birth:** _____

Due Date: _____ **Hospital in which baby will be born:** _____

Obstetrician: _____ **Feeding: Breast**_____ **Formula**_____

Occupation of Mother: _____ **Occupation of Father:** _____

Highest Education level of: Mother_____ **Father**_____

Number of years married before birth of first child: _____
Number of previous pregnancies: _____ **Number of living children:** _____
Weights at birth of previous children, and whether or not they were born approximately on the due date:

_____ **lbs., born at** _____ **months** _____ **lbs., born at** _____ **months**
_____ **lbs., born at** _____ **months** _____ **lbs., born at** _____ **months**
_____ **lbs., born at** _____ **months** _____ **lbs., born at** _____ **months**

Please list serious medical problems or congenital abnormalities of previous children:

_____
_____

Have any children died? _____ **If so, the reason for death:** _____

Have any of your children had any of the following problems soon after birth:
Jaundice, Pneumonia or difficulty in breathing, Convulsions, Anemia, Serious Infections, Serious Vomiting, Difficulty in Growing or Gaining Weight, Slowness in Development, Abnormal Bleeding, Blood Diseases?
If so please Specify: _____
_____

Have you or your previous children had an allergy to milk? _____
Has there been intermarriage of related family members? _____
Is there any family history of any of the following diseases in your relatives:

Arthritis	___	**Convulsive Disorders**	___	**Muscle Disease**	___
Asthma/Allergy	___	**Hearing loss (in young life)**	___	**Obesity**	___
Bleeding Disorder	___	**Heart Disease (less than 60 years old)**	___	**Stomach or Intestinal Disease**	___
Blindness (in young life)	___	**High Blood Pressure**	___	**Thyroid Disease**	___
Bone or Joint Disease	___	**Kidney Disease**	___	**Abnormalities at birth**	___
Cancer (under age 20)	___	**Lung Disease**	___	**Others**	___
Diabetes	___	**Mental Retardation**	___	_____	

If yes to any above, please specify: _____
_____

PERSONAL MEDICAL HISTORY DURING THIS PREGNANCY

Has there been any vaginal bleeding during this pregnancy? _____

If so when: _____

Has the Mother had many x-ray pictures, x-ray treatment or fluoroscopy? _____

If so please specify: _____

Have you had high blood pressure, virus infection, other illness or any other medical problems during this pregnancy? _____

If so please specify: _____

Is your obstetrician considering a Cesarean Section? _____

If yes, why? _____

Do you smoke? _____ **If so, how much?** _____

Are you on any special diet (e.g. vegetarian)? _____

Do you ingest any alcoholic beverages? _____

If yes, please specify which type and how much: _____

Have you had a recent kidney or bladder infection? _____

What drug have you taken during this pregnancy? _____

If the baby is a boy, do you want a circumcision? _____

If yes, is there any hemophilia or abnormal bleeding in your family? _____

Are you ready for this baby? _____