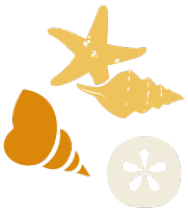

Beachside Pediatrics
of Naples

Prenatal Questionnaire

Mother to Be

Name: _____ Age: _____

Occupation: _____ Employer: _____

Important medical/surgical history: _____

_____

Medications/Prescription Drugs: _____

Use of Alcohol/Tobacco/Other: _____

Exposure to infections: _____

Prenatal History

Number of pregnancies: _____

Living children: _____

Premature deliveries: _____

Miscarriages/Abortions: _____

Problems at delivery: _____

Father to Be

Name: _____ Age: _____

Occupation: _____ Employer: _____

Important medical/surgical history: _____

_____

Medications/Prescription drugs: _____

Use of Alcohol/Tobacco/Other: _____

Exposure to infections: _____

Beachside Pediatrics
of Naples

Other children or stepchildren: ○Yes ○No

Name: _____

D.O.B: _____

Medical History: _____

Pregnancy history:

Was either parent sick at conception: ○Yes ○No

Either parent taking any type of medications at conception: _____

_____

Illness/Problems (including bleeding, infection, rupture of membranes, hospitalizations etc.) during pregnancy: _____

Ultrasound results: _____

Sex of the baby: ○M ○F ○Unknown Due Date: _____

Name of the Obstetrician: _____

Total weight gain: _____

Feeding preference: ○Breast ○Bottle

Anticipated method of delivery: ○Vaginal ○C-Section

Hospital delivering at: _____

Are you planning on attending prenatal classes: _____

Newborn questions: _____

_____

Adoption history (if applicable): _____

_____