CHEVY CHASE PEDIATRIC CENTER, P.C.
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PEDIATRICS
ADOLESCENT MEDICINE

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PRENATAL QUESTIONNAIRE

MOTHER

Name: _____

Age: _____

Occupation: _____

Blood type: _____

FATHER / PARTNER

Name: _____

Age: _____

Occupation: _____

Blood type: _____

HOME ADDRESS

_____

_____

TELEPHONE NUMBERS

Home: _____

Work (mother): _____ Cell phone: _____

Work (father/partner): _____ Cell phone: _____

OTHER CHILDREN

Name: _____ Age: _____

Name: _____ Age: _____

FAMILY HISTORY (include yourselves, your parents and your siblings)

	Maternal Side	Paternal Side
1. Food allergies	_____	_____
2. Pollen allergies (hay fever)	_____	_____
3. Asthma (reactive airway disease)	_____	_____
4. Congenital heart disease	_____	_____
5. Congenital hip dislocation	_____	_____
6. Other congenital defects	_____	_____
7. Eczema or other skin disorders	_____	_____
8. Jaundice in the newborn period	_____	_____
9. Premature infants	_____	_____
10. Recurrent ear infections	_____	_____
11. Recurrent urinary tract infections	_____	_____
12. Strabismus (lazy eye)	_____	_____
13. Sudden infant death syndrome	_____	_____

PREGNANCY HISTORY

1. Obstetrician:

_____

2. Planned hospital for delivery: _____

3. Date baby is expected: _____
4. Childbirth classes: _____

5. Number of previous pregnancies: _____

6. Number of miscarriages or stillbirths: _____

7. Difficulties getting pregnant: _____

8. List any problems you have had during this pregnancy:

_____

_____

_____

_____

9. List any diagnostic tests (blood work, amniocentesis, CVS, sonograms, etc.) done by your obstetrician:

_____

_____

_____

_____

10. If you are planning to breastfeed, has your obstetrician checked your breasts for flat or inverted nipples?

_____

11. Have you had any breast surgery in the past? If so, what procedure?

_____

12. Any special concerns about this pregnancy?

_____

_____

_____

DELIVERY PREFERENCES

1. Vaginal birth with anesthesia: _____

2. Vaginal birth without anesthesia (natural): _____

3. Planned C-Section: _____

CARE OF THE NEWBORN

1. Type of feeding: breast _____ formula: _____

2. Planned duration of breastfeeding: _____

3. Expected length of stay in the hospital: _____

4. Mother returning to work: yes _____ no _____

5. Plans for help at home in the first few weeks:

_____

_____

_____

6. Do you plan to circumcise your baby? yes _____ no _____

7. Any special concerns or questions about the baby?

_____

_____

_____

_____

8. If you have other children at home, do you have concerns about sibling issues?

_____

_____