



We want you well.

Prenatal Visit

Today's date _____

Welcome to our office and to your medical home. We appreciate you completing the following form so that we can better understand and meet your needs. Please give the completed form to the physician during your consult visit.

Parent #1 name _____ Occupation _____

Home phone _____ Work phone _____ Cell phone _____

Email address _____

Parent #2 name _____ Occupation _____

Home phone _____ Work phone _____ Cell phone _____

Email address _____

Due date _____ Obstetrician _____

Hospital _____ Insurance carrier _____

Will this be your first child? Yes No

Do you plan to breastfeed your child? Yes No

Do you have or need daycare plans? Yes No

Have you experienced any problems / complications during this pregnancy? Yes No

Do you have any special needs that we should be aware of? Yes No

How did you hear about our office? _____

Have you been exposed to any of the following during this pregnancy?

Lead / Toxins Yes No Drugs / Medications Yes No

Infectious Diseases Yes No Alcohol / Cigarettes Yes No

Is there any significant family medical history that we should know about?

Seizures Yes No Mental Illness Yes No

Early Heart Problems Yes No Kidney Disease Yes No

Cystic Fibrosis Yes No SIDS Yes No

Birth Defects Yes No Mental Retardation Yes No

Alcoholism Yes No Hearing Loss Yes No

Sickle Cell Yes No Asthma / Allergies Yes No

Stralismus Yes No

Other _____