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PRENATAL INFORMATION

Infant's last name _____ Due date _____

Whom may we thank for this referral _____

Obstetrician _____ Hospital _____

Mother's name _____ Age _____ Father's name _____ Age _____

Number of pregnancies, including the present _____ Living children _____ Miscarriages _____

Mother's medical history

A. This pregnancy _____ Male _____ Female _____ Unknown to parents

1. Special problems:

Fever _____
Rashes _____
Infection _____
Bleeding _____
Excess wt. gain _____

High blood pressure _____
Diabetes _____
IVF _____
Group B Strep Carrier _____
Other _____

2. Medications/Drugs taken during pregnancy and when: _____

3. X-rays or injury during pregnancy and when: _____

4. Blood type/Rh: Mother _____ Father _____

5. Cesarean section planned: Yes _____ No _____ Reason _____

B. Previous Pregnancies:

Yr. of Birth	Sex	Birth Wt.	Special Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. Past Medical History: (List significant illnesses, surgery, injuries, hospitalizations, allergies, etc.) _____

FATHER'S MEDICAL HISTORY: (List significant illnesses, surgery, injuries, hospitalizations, allergies, etc.) _____

FAMILY MEDICAL HISTORY: (List conditions of possible importance in the care of your infant, such as diabetes, frequent miscarriages, epilepsy, bleeding disorders, serious anemia, muscular diseases, newborns with serious difficulties, twins, etc.) _____

