

TOWN CENTER PEDIATRICS

Prenatal Consultation Date: _____

Appointment with Dr: _____ Baby's Due Date: _____
Mother's Name: _____ Father's Name: _____
Home Address: _____ Telephone #: _____
Referred By: _____

OB: _____ Hospital: _____ Marital Status: S / M / D
Do you expect to have a C/S? Yes / No _____ Is baby's sex known? Yes/No _____

Maternal History:

Age: _____ Blood Type: _____ Which pregnancy (#) is this for you: _____
of miscarriage: _____ #of Live Births: _____ Did all previous babies come on time? Y/N
Were previous babies vaginal or C/Section births _____ Were there are delivery complications? Y / N
How much did the largest baby weigh? _____ How much did the smallest baby weigh? _____

Maternal illness during pregnancy (check any that apply)

____ High Blood Pressure ____ Bleeding ____ Venereal disease ____ Anemia
____ Diabetes ____ Severe vomiting ____ Swollen Ankles ____ Group B Strep
____ Protein in urine ____ German Measles ____ Urinary Infection ____ Excessive wt gain

Other problems: _____

Maternal medications taken during this pregnancy (check any that apply)

____ Vitamins ____ For swelling ____ To sleep ____ For nausea
____ Iron ____ For high blood pressure ____ For nerves ____ For infection
____ Aspirin ____ Hormones ____ Pep pills ____ Other

During this pregnancy did you: (check any that apply)

____ Smoke ____ Drink alcohol ____ IV drug use ____ Cocaine ____ Have x-rays

Other comments: _____

Family History: (Of the Expected Baby)

Name	Date of Birth	Birthplace	Health status
Mother: _____			
Father: _____			
Siblings: _____			
(of the _____			
new baby) _____			

Religious affiliation (optional) _____

Have any of this child's blood relatives had: (check any that apply)

____ Severe anemia ____ Asthma ____ Short stature ____ Bleeding disorder
____ Tuberculosis ____ Birth Deformity ____ Mental retardation ____ Allergy/hay fever
____ Inherited diseases ____ Emotional illness ____ Heart disease ____ Bone/joint disease
____ Digestive disease ____ Cancer ____ Diabetes ____ Neurologic disease
____ Thyroid disease ____ Eye or ear disease ____ Kidney disease ____ Obesity
____ Cystic fibrosis ____ Down's syndrome ____ Convulsions/epilepsy

Other comments: _____

Prenatal preparation and plan:

Prenatal classes Mom Y / N Dad Y / N

Books / Videos / other educational materials used to prepare for birth and child care:

Father in delivery room Y / N Circumcision Y / N
Breast feeding Y / N Formula feeding Y / N
Rooming in Y / N Who will be the primary care giver for this child? _____

Insurance information: Mother's insurance: _____ Father's insurance: _____