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Kathleen Wania, M.D.

PRENATAL/NEWBORN QUESTIONNAIRE

TODAY’S DATE: ____/____/____

MOTHER’s Name: _____ FATHER’s Name: _____

Date of Birth: ____/____/____ Date of Birth: ____/____/____

Address: _____ Address: _____

Home/Cell #: _____ Home/Cell #: _____

Occupation/Employer: _____ Occupation/Employer: _____

PREGNANCY INFORMATION

BABY’s full name: _____
FIRST MIDDLE LAST

BABY’s full name: _____
FIRST MIDDLE LAST

Due Date / DOB: ____/____/____

Confirmed by Ultrasound? Yes No

Obstetrician: _____

Hospital: _____

Birth Center: Yes No

Complications: (Please mark **X** in box if Yes)

High Blood Pressure Diabetes Tobacco Use

Other: _____

Medications: _____

Describe any Past Pregnancies and Results: _____

FAMILY HISTORY

Please mark **X** in box if Applicable and list Relatives as they are Related to the Child.

- | | Relative(s) | | Relative(s) |
|-------------------------------------|-------------|------------------------|-------------|
| ▪ Anemia/Bleeding Problems | _____ | ▪ Heart Attack/Disease | _____ |
| ▪ Alcohol/Drug Problems | _____ | ▪ High Blood Pressure | _____ |
| ▪ Allergies | _____ | ▪ High Cholesterol | _____ |
| ▪ Asthma | _____ | ▪ Immune Comprised | _____ |
| ▪ Birth Defects | _____ | ▪ Mental Retardation | _____ |
| ▪ Cancer | _____ | ▪ Muscle Disease | _____ |
| ▪ Child(ren) with Heart Defect | _____ | ▪ Psychiatric Illness | _____ |
| ▪ Chronic Childhood Illness | _____ | ▪ Seizures | _____ |
| ▪ Deafness | _____ | ▪ Spinal Bifida | _____ |
| ▪ Diabetes | _____ | ▪ Thyroid Problems | _____ |
| ▪ Kidney Disease | _____ | ▪ Tuberculosis | _____ |
| ▪ Early Childhood Death/SIDS | _____ | | |
| ▪ Behavior/Learning/Speech Problems | _____ | | |



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▪ Other: _____