ENGLISH ROAD PEDIATRICS & ADOLESCENT MEDICINE, LLC

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PRENATAL/NEWBORN QUESTIONNAIRE

TODAY'S DATE: _____/_____/_____

Parent #1's Name:_____ Date of Birth: _____/_____/_____
Address: _____ Phone #:_____
Email: _____ Occupation/Employer:_____
Parent #2's Name:_____ Date of Birth: _____/_____/_____
Address: _____ Phone #:_____
Email: _____ Occupation/Employer:_____

PREGNANCY INFORMATION

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 _____
▪ Other: _____