ENGLISH ROAD PEDIATRICS & ADOLESCENT MEDICINE, LLC

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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 <u>Related to the Child</u>.

	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: _____