# Pediatric Healthcare Associates

**DATE OF PRENATAL VISIT: _____** **PHYSICIAN: _____**

Parent 1:_____
(First) (Last) (DOB)

Parent 2: _____
(First) (Last) (DOB)

Address: _____
Home Phone: _____ Cell Phone: _____
Referred by: _____

## Prenatal History

Obstetrician: _____ Delivery Hospital: _____

Due Date: _____ Previous Pregnancies: ☐ Yes ☐ No

## Current Pregnancy Problems:

☐ Hypertension ☐ Vomiting ☐ Maternal Illness
☐ Diabetes ☐ Bleeding ☐ Poor growth of fetus
☐ Amniotic fluid – too much or too little ☐ Premature Labor ☐ Abnormal growth of fetus
☐ Abnormal position of fetus (breech)

**Medications:**

_____
_____

## Family History (check all that apply)

☐ Anemia ☐ Bleeding Disorder ☐ Hypertension ☐ Seizures ☐ Diabetes
☐ Allergies ☐ Cystic Fibrosis ☐ Thyroid Disease ☐ Asthma ☐ Cancer
☐ Hepatitis ☐ Mental Retardation ☐ Heart Disease ☐ Congenital Hip Problems
☐ Lazy Eye ☐ Intestinal Problems ☐ Birth Defects ☐ Muscle or Joint Disorder

## Plans for your baby

☐ Breastfeed ☐ Bottle feed
Have you discussed the issue of circumcision if you have a boy? ☐ Yes ☐ No
Do you have help during the first weeks at home with the baby? ☐ Yes ☐ No
Are you planning to work after the birth of the baby? ☐ Yes ☐ No
How soon? _____

Which of our offices will you be going to?
☐ Bridgeport ☐ Fairfield ☐ Shelton ☐ Stratford – Hawley Lane ☐ Stratford – Main St ☐ Trumbull