



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

Medications:

Family History (check all that apply)

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

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
- Trumbull