## PRENATAL VISIT

BABY'S MOTHER							
Name: Married	Cinalo	Age:Occupation: Number of living Children:					
Number of previous programaio	Sirigle	Number of living Children					
Problems with Previous Pregnance	5	_Number of living Children:					
	ricies.						
Number of children delivered pro	ematurely (pric	or to 38 weeks gestation)?					
Have any of your previous childs	ren had any of	the following:					
Newborn Jaundice	SIDS	(Sudden Infant Death Syndrome)					
Congenital Heart Diseas	Newborn Jaundice SIDS (Sudden Infant Death Syndrom Congenital Heart Disease Serious infection in the newborn period (first 30 days)						
During this pregnancy, have youSmoked? If yes, how mi							
Drank alcoholic beverage	es? If ves. how	much?					
Taken Prescription or No	onprescription [	Orugs? If yes, which drugs?					
During this pregnancy, or at anyThyroid DiseaseFifth's DiseaseHigh Blood PressureBleeding DisorderHepatitisRubella	Diabet Sickle Group Toxopl	st, have you been diagnosed with esEpilepsy Cell DiseaseHerpes B StrepLupus lasmosisAsthma Cytomegalovirus) Infection					
BABY'S FATHER: Name:		Age:					
Occupation:							
Health Problems:							
BABY'S BROTHERS AND/O	R SISTERS						
Name:	Age:	Health Problems:					
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THIS	S PRE	GNANCY: When is yo	ur due date?					
Do you anticipate avaginal orC-section delivery?  Who is your obstetrician? Where will you deliver?  Do you plan to: Breast Feed Bottle Feed Breast & Bottle Feed								
Who	is vou	r obstetrician?	Where wil	l vou	deliver?			
Do v	ou pla	n to: Breast Feed	Bottle Feed	4	Breast & Bottle Feed			
Formula Proforonco:								
If you have a boy, will you request a circumcision? Yes No								
		e a car seat for the baby?			Yes No			
		end childbirth classes?	•		Yes No			
		returning to a job after deliv			Yes No			
VVIII	you be	returning to a job after deliv	reiy:		NO			
<b>FAMILY MEDICAL HISTORY:</b> Please answer the following regarding your family medical background. Circle Yes or No, and add comments where appropriate.								
Yes	No	Any tobacco smokers	Yes	No	Asthma?			
		In your household?	Yes	No	Emphysema?			
Yes	No	Family with high cholestero	l? Yes	No	Liver Diseases?			
Yes	No	Heart attacks or Strokes	Yes	No	Hepatitis B?			
		Before 50 years?	Yes	No	Cirrhosis?			
Yes	No	Diabetes in kids under	Yes	No	Other?			
		18 years of age?	Yes	No	Pancreas Disease?			
Yes	No	Diabetes in adults?	Yes	No	Ulcer Disease?			
Yes	No	High Blood Pressure?	Yes	No	Hearing Deficits?			
Yes	No	Kidney Disease?	Yes	No	Learning Disorder?			
Yes	No	Kidney Stones?	Yes	No	Attention Deficit/			
Yes	No	Food Allergies?			Hyperactivity?			
Yes	No	Anesthetic Reaction?	Yes	No	Immune Deficiency			
Yes	No	Seizures due to fever?			Diseases?			
Yes	No	Mental Retardation?	Yes	No	Arthritis?			
Yes	No	Endocrine Diseases?	Yes	No	Lupus?			
Yes	No	Thyroid Gland?	Yes	No	Bleeding Disorders?			
Yes	No	Growth Hormone?	Yes	No	Chronic Anemia?			
Yes	No	Adrenal Gland?	Yes	No	Sickle Cell Anemia?			
Yes	No	Pituitary Gland?	Yes	No	Thalassemia?			
Yes	No	Cystic Fibrosis?	Yes	No	Cancer?			
Yes	No	Eye Disease?			Type:			
Yes	No	Lazy Eye?	Yes	No	Eczema or Psoriasis?			
Yes	No	Strabismus (Crossed Ey	es)?					
Yes	No	Loss of Vision?						
Yes	No	Cataracts?	! <b>.</b>	il. Di				
Yes	No	Other Health Problems that	run in your tam	ily. Pi	ease describe.			
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