Sawgrass Pediatrics

9750 NW 33rd Street
Suite 101
Coral Springs, FL 33065
Telephone # (954) 752-9220
Fax # (954) 752-1549

Susan Waters, M.D., F.A.A.P.
Lori Miller, M.D., F.A.A.P.
Anthony Martell, M.D., F.A.A.P.
Alina Di Liddo, M.D., F.A.A.P.
Jordan Mussary, MD., F.A.A.P.
Alan Cadiz, D.O., F.A.A.P.
Susan Shulman, D.O., F.A.A.P.

9801 Glades Road
Boca Raton, FL 33428
Telephone # (561) 487-9912
Fax # (561) 487-5070

Prenatal Questionnaire

Registration Form			Primary Language	Race	Date
Check One	New Patient				mm / dd / yyyy
	Existing Patient				

Mother's/Guardian Information	Due Date________________				
Mother's/Guardian's Name			D.O.B.	mm / dd / yyyy	AGE:
Home address			Apt/Bldg #		
City, State, Zip Code					
(Circle One)	Married	Single	Divorced	Legally Separated	Widowed
Home phone			Cell Number		
Home E-mail Address					
Social Security Number					
Drivers License					
Employer Name			Work Number		

Father's/Guardian Information					
Father's/Guardian's Name			D.O.B.	mm / dd / yyyy	AGE:
Home Address			Apt/Bldg #		
City, State, Zip Code					
(Circle One)	Married	Single	Divorced	Legally Separated	Widowed
Home phone			Cell Number		
Home E-mail Address					
Social Security Number					
Drivers License					
Employer Name			Work Number		

Obstetrician's Name	Hospital
Who referred you to our practice?	

Sawgrass Pediatrics

Prenatal Questionnaire

1.	Is this your first pregnancy?	Yes ☐	No ☐
2.	Have you had any previous miscarriages?	Yes ☐	No ☐
3.	Did you any difficulty conceiving?	Yes ☐	No ☐
4.	Did you use any birth control methods prior to conceiving?	Yes ☐	No ☐
	If so, which one(s)? ☐ "Rhythm" method ☐ Oral Contraceptives ☐ Condoms ☐ Diaphragms ☐ Foam/Jellies ☐ Intrauterine Device		
5.	Have you had any prenatal screening (Tay-Sachs disease etc)	Yes ☐	No ☐
	Amniocentesis?	Yes ☐	No ☐
6	Have you had any medical problems during your pregnancy?	Yes ☐	No ☐
7.	Did you have any of the following problems during the first three	Yes ☐	No ☐
	months of your pregnancy ☐ Fever	Yes ☐	No ☐
	☐ Bleeding		
	☐ Skin Rash		
	☐ Vomiting		
8.	Have you taken any drugs or medication during your pregnancy?	Yes ☐	No ☐
9.	Have you consumed any alcoholic beverages during your pregnancy?	Yes ☐	No ☐
10.	Have you smoked during your pregnancy	Yes ☐	No ☐
11.	Do you know your blood type and Rh status?	Yes ☐	No ☐
12.	Have you had:		
	Rubella (3 day German Measles)?	Yes ☐	No ☐
	The Rubella immunization shot after 1969?	Yes ☐	No ☐
	A blood test to determine your susceptibility to Rubella?	Yes ☐	No ☐
13.	Is there a personal or family history of:		
	☐ Allergies	☐ Heart Disease	☐ Thyroid Disease
	☐ Anemia/Blood Disease	☐ Hepatitis	☐ Tuberculosis
	☐ Cancer	☐ Herpes	☐ Toxemia of Pregnancy
	☐ Diabetes	☐ Newborn Jaundice	☐ Venereal Disease
14.	Have you had a previous Cesarean Section delivery or previous surgery?	Yes ☐	No ☐
15.	Have you had any newborn infants who were born prematurely or who developed any illness in the first month of life?	Yes ☐	No ☐
16.	Have you or are you planning to participate in childbirth classes?	Yes ☐	No ☐
17.	Do you plan to: ☐ Nurse ☐ Formula		
18.	Do you plan on having Rooming-in while you are in the hospital?	Yes ☐	No ☐
19.	If you have a boy do you wish to have him circumcised?	Yes ☐	No ☐
20.	Have you purchased an infant **CAR SEAT**?	Yes ☐	No ☐

X Parent/Guardian Signature	mm / dd / yyyy Date