Sawgrass Pediatrics

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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?	

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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	m m / d d / y y y y
Parent/Guardian Signature	Date