CHEVY CHASE PEDIATRIC CENTER, P.C.
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PEDIATRICS
ADOLESCENT MEDICINE

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PRENATAL QUESTIONAIRE

PARENT 1

Name: _____

Age: _____ Blood Type: _____

Home Address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Occupation: _____

PARENT 2 (if applicable)

Name: _____

Age: _____ Blood Type: _____

Home Address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Occupation: _____

Relationship to Parent 1: _____

OTHER CHILDREN

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

FAMILY HISTORY *(Please include information, if known, about parents, grandparents, and siblings, including egg/sperm donation and adoption. Indicate who on the line next to the item.)*

1. Food allergies: _____
2. Environmental or seasonal allergies: _____
3. Asthma (reactive airway disease): _____
4. Heart disease: _____
5. Congenital hip dislocation: _____
6. Other congenital defects: _____
7. Eczema or other skin disorders: _____
8. Jaundice in the newborn period: _____
9. Premature infants: _____
10. Seizures: _____
11. Recurrent infections: _____
12. Strabismus (lazy eye): _____
13. Sudden infant death syndrome: _____

PRENATAL HISTORY

1. Prenatal Care Provider (OB, midwife, group): _____
2. Planned hospital for delivery: _____
3. Expected due date: _____
4. Number of previous pregnancies: _____
5. History of previous miscarriage or stillbirth? _____
6. Difficulties getting pregnant? _____
7. Donor egg, donor sperm, or surrogate used? _____

8. List any problems during this pregnancy: _____

   _____

   _____

   _____

9. List any diagnostic tests (blood work, amniocentesis, CVS, sonograms, etc.) done by the prenatal care provider: _____

   _____

   _____

   _____

10. Childbirth classes: _____
11. Infant CPR class: _____
12. Any special comments or concerns about this pregnancy? _____

    _____

    _____

    _____

13. What is your plan or desire for delivery (c-section, “natural childbirth”, induction of labor, etc)?

    _____

    _____

    _____

CARE OF THE NEWBORN

1. Feeding plan (breast milk, formula, both): _____
2. If planning on breastfeeding, goal duration: _____

3. Do you have any concerns about breastfeeding? (Flat or inverted nipples, medications, previous surgeries, lactation induction, etc.): _____

   _____

4. Planned parental leave? Yes _____ No _____
5. If yes, who is taking leave and how long is the anticipated leave? _____

   _____

6. Plans for help at home in the first few weeks: _____

   _____

   _____

7. Do you plan to circumcise your baby? Yes _____ No _____
8. Any special concerns or questions about the baby? _____

   _____

   _____

9. If you have other children at home, do you have concerns about sibling issues? _____

   _____

   _____

10. Is there anything else that you would like for us to know about your family? _____

    _____

    _____

    _____