Prenatal Questionnaire

1. Name_____

	Mother	Father	Last Name
Ages:	_____	_____	
Occupations:	_____	_____	
Health Problems:	_____	_____	

2. Marital Status: Married ( ) Single ( ) If married, number of Years:_____
   Children: Yes ( ) No ( ) If yes, Ages:_____

3. Due Date:_____ What type of delivery planned: Natural ( ) C-Section ( )
   Ultrasound determine sex of baby: ( ) Boy ( ) Girl ( ) Unknown

4. Where do you plan to deliver? Hospital ( ) Which one?_____ or Alternate Birthing Center ( )

5. Who is your OB Physician:_____

6. Has your pregnancy been healthy? Yes ( ) No ( ) Please Explain:
   _____
   _____

7. Are there any inherited or family diseases we should be aware of?
   _____

8. Smoking History: Mother: Y or N Father: Y or N
   Smoked while pregnant: Y or N

9. Other medications/drugs during pregnancy:
   _____

10. We plan to: ( ) Breastfeed ( ) Bottle feed
    If other children—Did you breastfeed with any previous children: ( ) Yes ( ) No

11. We already have a car seat: ( ) Yes ( ) No

12. Do you have any special questions or concerns?
    _____
    _____

13. Referred by:
    _____