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PEDIATRIC
Heart Specialists
Diagnosis & Treatment of Cardiology Disorders
Fetal/Neonatal through Young Adults
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New Fetal Patient Questionnaire

Name _____ DOB: ____/____/____ Today's Date: _____/____/_____

Spouse/Partner's Name _____ Estimated Due Date ___/___/____ Current Gestation: _____

Perinatologist: _____ Obstetrician: _____

Reason for Referral: _____ Delivering Hospital: _____

Drug Allergies: _____ Current Medications: _____

Medical History

	Yes	No		Yes	No		Yes	No
Diabetes			Liver (i.e. Hepatitis)			Ulcers		
Hypertension			Thyroid			Arthritis		
Heart Disease			Seizures/Epilepsy			HIV		
Asthma/Lung			Blood Clots			Blood Transfusions		
Kidney			Lupus			Trauma		
Depression			Other:					

If answered yes to any above, please explain: _____
_____

Pregnancy History

Year	Weeks at Delivery	Boy/Girl	Weight	Vaginal or Cesarean	Indication for Cesarean	Complications

Social History

	Yes	No		Yes	No
Tobacco			Wear seatbelt?		
Alcohol			Exercise		
Illicit/Recreational Drugs					

Did you have any prenatal genetic testing or an amniocentesis performed? Y N If so, what were the results? _____

Are there any other concerning physical findings on your baby's sonogram? Y N
If yes, please explain _____

Family History

	Yes	No		Yes	No		Yes	No
Congenital Heart Disease			Birth Defects			Recurrent Pregnancy Loss		
Sickle Cell Trait/Disease			Cystic Fibrosis			Genetic Syndromes		
Neural Tube Defects			Down Syndrome			Diabetes		
Autoimmune Disorders			Lupus					

Patient Signature: _____ Physician Signature: _____