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PEDIATRIC
Heart Specialists
Diagnosis & Treatment of Cardiology Disorders
Fetal/Neonatal through Young Adults
Board Certified, Pediatric Cardiology

Christine Glasow, MD
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Fetal Follow-up 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

Have there been any changes in your medical history since your last visit? Y N
If yes, please explain: _____

_____

Have you had 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
_____

_____

Social History

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

Patient Signature: _____ Physician Signature: _____