

# Ivy Children's Clinic Prenatal Questionnaire

First, print out this form. Fill it out. Bring it with you to our office.

Today's Date: \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation: \_\_\_\_\_

Father's Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Due Date: \_\_\_\_\_

Name of Obstetrician: \_\_\_\_\_

Hospital where the delivery is scheduled: \_\_\_\_\_

Mother's age \_\_\_\_\_

Single birth \_\_\_\_\_ or Multiple birth \_\_\_\_\_ pregnancy? (list number of fetuses)

If you have a boy, will you request a circumcision? \_\_\_\_\_ Yes \_\_\_\_\_ No

Maternal medical problems

If "yes", list

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Maternal use of medications other than vitamins

If "yes", list

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Any problems on prenatal ultrasound?

If "yes", list

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Maternal use of tobacco/alcohol during pregnancy? If "yes", explain:

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List any significant chronic illnesses in the family that the parents or other children have had:

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Is there a smoker in the household? \_\_\_\_\_

Are you planning to breastfeed \_\_\_\_\_ or bottle-feed \_\_\_\_\_ or both \_\_\_\_\_? (check )