PANORAMA
PEDIATRIC GROUP

Prenatal Questionnaire

Contact Information

Mother's Name:_____ Second Parent's Name:_____

Mother's Date of Birth:_____ Second Parent's Date of Birth:_____

Mother's Maiden Name (*if applicable*): _____ Baby's Last Name:_____

Baby's insurance: _____How did you hear about our office? _____

Pregnancy

Due Date:_____ Is this your first child? Yes No

Complications or concerns in your pregnancy: _____

Maternal medical problems:_____

Have you used alcohol or recreational drugs during this pregnancy? Yes *(please list)*_____ No

Who is your Obstetrician? _____ Hospital of delivery?_____

Do you know if your baby is a boy or girl? _____ Do you plan to breast or bottle feed? _____

Family History

Have the baby's parents, aunts/uncles or grandparents had any genetic/inherited diseases in their childhood? (Common examples would be cystic fibrosis, sickle cell disease, thalassemia): _____

_____

Social History

Mother's Occupation? _____Second Parent's Occupation: _____

If mother works, will she return to work after the baby is born? Yes No

If yes, who will provide childcare?_____

About your home

Was it built before 1978?	Yes	No
If yes, is there any peeling or exposed old paint?	Yes	No
Are there any smokers in the household?	Yes	No
Is there a pool at home?	Yes	No
Are there firearms at the home?	Yes	No
Are there smoke and carbon monoxide detectors at home?	Yes	No

Account Number (office use only): _____