PRENATAL INTERVIEW FORM
(PLEASE COMPLETE AND BRING WITH YOU FOR YOUR INTERVIEW)

This information will be kept in our files for office use only. If you choose our doctors as your primary care physicians, this information will become part of your child's permanent record in our office.
MD you are seeing today _____ Today's Date_____ Estimated Delivery Date _____

Name of Insurance carrier that the baby will be added to? _____

NAME _____

Father's Last name *(please print)* First Name Initial

_____

Mother's Last name *(please print)* First Name Initial

_____

Address

May we call you to follow up after today's visit? Yes ☐ No ☐ Phone #: _____

Where will baby be delivered? (*HOSPITAL*) _____ OB/GYN _____

FAMILY HISTORY

	Birth Date	Ht.	Wt.	Medical Problems	Education Level
Father					
Mother					

Mother: Have you had breast surgery? Yes ☐ No ☐

Did you take hormones or medicines during pregnancy? Yes ☐ No ☐
(*Explain*) _____

Did you drink alcohol or smoke during pregnancy? Yes ☐ No ☐

Do you or the father have any history of vaginal group B strep, STD, etc.? Yes ☐ No ☐

Do you have an infant car seat that meets current safety standards? Yes ☐ No ☐

Any history in baby's close relatives (grandparent, sibling, aunt, uncle) of: *(please check appropriate items)*

___Interrupted Pregnancies ___HIV/AIDS ___Birth Defects ___Kidney Disease ___Substance Abuse
___Tuberculosis ___Diabetes ___Chemotherapy ___Thyroid Disease ___Other
___Allergies ___High Cholesterol ___Bleeding Tendencies ___Liver Disease
___Convulsions/Epilepsy ___High Blood Pressure ___Sudden/UnexpectedDeath ___Mental or Emotional Problems
___Other Heart Disease ___Early Heart Attacks or fatality from illness ___Cancer

Other Children? *(Please list name, age and gender)*_____

_____

Doctor Notes:

_____

Whom may we thank for referring you to our practice? _____

Do we have permission to use your name in our thank you correspondence? _____Yes ☐ No ☐