



We would appreciate if you could please fill out the following information so that we can begin your baby's medical care.

Date: _____ Doctor: _____

Mother's Name: _____

Father's Name: _____

Address & Telephone Number: _____

Who referred you? _____

Who is your Obstetrician/Midwife? (If using a Midwife, what is the name of her practice?) _____

When are you due? _____

Where will you deliver? _____

Have you taken pre-natal classes? _____

If you are having a boy, have you decided on whether or not you will get a circumcision?

Will you be breast feeding or bottle feeding? _____

Do you have positive culture for Group B Strep (GBS)?(If you are using a Midwife, do you need a prescription for use in labor?) _____

Are you absolutely sure you are negative for Hepatitis B? _____

Have you had any complications at all during your pregnancy? (including infections, bleeding, etc..)

Are you taking any medications? _____ If yes, please list: _____

Are you taking pre-natal vitamins? _____ Which Brand? _____

How many times have you been pregnant? _____

How many children have you delivered? _____ Miscarriages? _____ Stillborn? _____

Do you or the baby's father have any medical diseases? _____

If yes, please list: _____

Is there a history of any disease in either of your families? _____

If yes, please list: _____