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PEDIATRIX CARDIOLOGY

FETAL PATIENT HISTORY QUESTIONNAIRE

Reason for your visit: _____

Referring physician: _____

Preferred phone number: _____

Preferred email address: _____

PERSONAL HISTORY

Marital Status:
☐ Single ☐ Married ☐ Long-term Relationship ☐ Divorced ☐ Widowed

Name: _____

Occupation: _____

Partner name: _____

Partner age: _____ Partner occupation: _____

PAST MEDICAL HISTORY

☐Autoimmune disease ☐High blood pressure ☐ Thyroid disease
☐Diabetes ☐Heart disease ☐ Obesity
☐Epilepsy ☐ Kidney disease ☐ Other_____
☐Genetic syndrome ☐ Liver disease

PRIOR PREGNANCY HISTORY

☐ No prior pregnancies

YEAR	TYPE OF DELIVERY	COMPLICATIONS	LIVING CHILD

CURRENT PREGNANCY HISTORY

Estimated date of conception: _____

Estimated date of delivery: _____

Current gestation: _____weeks_____days

Prior ultrasound results: _____

Complications during this pregnancy: _____

Testing during this pregnancy and results (if applicable):
☐First trimester screen (blood test and ultrasound) _____
☐Chorionic villus sampling _____
☐Amniocentesis _____
☐Cell free fetal DNA _____

MEDICATIONS (INCLUDE THOSE YOU WERE ON DURING BEGINNING OF PREGNANCY)

MEDICATION	DOSE	FREQUENCY	DATE STARTED/STOPPED

FAMILY HISTORY (IN YOU, FATHER, OR BABY'S BROTHERS/SISTERS)

☐Arrhythmias
☐Autoimmune disease
☐Cardiomyopathy
☐Congenital heart disease
☐Genetic syndrome
☐ Other_____

SOCIAL HISTORY

	NEVER	CURRENT	FORMER
TOBACCO			
ALCOHOL			
DRUGS			