



## ULTRASOUND QUESTIONNAIRE

YOUR NAME \_\_\_\_\_ DOB: \_\_\_\_\_

Please answer the following questions:

- Y N Do you have Diabetes, type 1 or 2?
- Y N Do you have Gestational Diabetes?
- Y N Do you have Lupus?
- Y N Do you have Marfan Syndrome?
- Y N Do you have Phenylketonuria?
- Y N Do you have Sjogren's Syndrome?
- Y N Did this pregnancy result from IVF treatment?
- Y N Do you have a heart defect? .What defect? \_\_\_\_\_
- Y N Does the father of pregnancy have a heart defect?  
If yes, what defect? \_\_\_\_\_
- Y N Do you or the father of pregnancy have a previous baby born with a heart defect? If yes, what defect? \_\_\_\_\_
- Y N Have you had a prior baby born more than 3 weeks before due date? If yes, how many weeks? \_\_\_\_\_

Check Reason:

\_\_\_\_ Water broke

\_\_\_\_ Went into labor

\_\_\_\_ Other: \_\_\_\_\_

Please list any medications other than vitamins you have taken during this pregnancy:

\_\_\_\_\_

