



**Pediatric & Congenital
Cardiology Associates**

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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



512-777-2917



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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			

