Spring Valley Pediatrics PLLC

Patient Name: _____

PREGNANCY HISTORY

Obstetrician: _____ Hospital for Delivery: _____

Expected Due Date: _____ Number of previous pregnancies: _____

Any previous stillbirths, miscarriages? _____

Attendance at childbirth and/or Breastfeeding Courses: _____

Have you taken any medications? _____

During this pregnancy have you had any:

Ankle swelling_____ high blood pressure_____ exposure to disease_____

Any tests or procedures other than routine done by your obstetrician (sonogram, nuchal translucency, amniocentesis, CVS, etc.): _____

_____

Any special concerns on your part regarding your pregnancy? _____

_____

Care of Newborn:

☐ Breastfeeding Planned duration of breastfeeding? _____

☐ Bottle feeding

Mother returning to work? _____ When? _____

Planned help at home in the first weeks? _____

Daycare/childcare plans? _____

Circumcision? _____ Car seat? _____

Do you have any pets? _____

Tobacco use at home? _____

Any other questions? _____

_____