**Children's Heart Clinic**
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# FETAL PATIENT QUESTIONNAIRE

Name: _____ D.O.B: _____ Today's Date: _____

Spouse/Partner's Name: _____ Estimated Due Date: ___/___/___ Current Gestation: _____

Obstetrician: _____ Delivering Hospital: _____

Reason For Referral: _____ Current Medications: _____

Drug Allergies: _____

## Medical History

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Diabetes | | | Liver (i.e. Hepatitis) | | | Ulcers | | |
| Hypertension | | | Thyroid | | | Arthritis | | |
| Heart Disease | | | Seizures/Epilepsy | | | HIV | | |
| Asthma/Lung | | | Blood Clots | | | Blood Transfusions | | |
| Kidney | | | Lupus | | | Trauma | | |
| Depression | | | Other: | | | | | |

If answered yes to any above, please explain: _____

_____

## Pregnancy History

| Year | Weeks at delivery | Boy/Girl | Weight | Vaginal or Cesarean | Indication for Cesarean | Complications |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Social History

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Tobacco | | | Wear seatbelt? | | |
| Alcohol | | | Exercise | | |
| Illicit/Recreational Drugs | | | | | |

Did you have any prenatal genetic testing or an amniocentesis performed? Y N If Yes, what were the results? _____

Are there any other concerning physical findings on your baby's sonogram? Y N If Yes, please explain:_____

## Family History

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Congenital Heart Disease | | | Birth Defects | | | Recurrent Pregnancy Loss | | |
| Sickle Cell Trait/Disease | | | Cystic Fibrosis | | | Genetic Syndromes | | |
| Neural Tube Defects | | | Down Syndrome | | | Diabetes | | |
| Autoimmune Disorders | | | Lupus | | | | | |

**Print Name**_____ **Date**_____

**Signature**_____