6255 N Fresno St.
Suite 106
Fresno, CA 93710
Tel: (559) 435-1500 Fax: (559) 478-5082
Email: info@firstpeds.com
URL: www.firstpeds.com

Prenatal Consultation Form

Congratulations on the newest addition to your family! We look forward to providing you and your child with quality, compassionate care. Please complete the following and bring with you to your prenatal consultation. This information is protected under HIPAA and will be used for our office use only. Should your child become our patient, this information will become a part of his/her permanent record.

Date: _____ Due Date: _____

Name of Child (if known): First _____Middle _____Last_____

Sex of Child, if known (please circle): Boy Girl Surprise

Contact Information:

Mother's full name: _____

Father's full name:_____

Home address:_____

City_____ State_____ Zip_____

Home phone: (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

Email: _____Insurance: _____

Pregnancy/Birth Plan:

OB/Gyn:_____ Hospital:_____

Location of Prenatal care:_____ Weeks when prenatal care began:_____

Expected delivery (please circle): Vaginal C-section (due to):_____

Expected feeding: Breastfeeding Formula Both

Mom's medications: Prenatal Vitamins other:_____

Pregnancy complications:_____

Family History:

Other children? (*please list name(s), age and gender*): _____

_____

Any medical history in baby's close relatives (parents, grandparents, siblings, aunts/uncles, cousins) of: (*please check all that apply)*

_____ Allergies
_____Birth Defects
_____Bleeding Tendencies
_____Cancer
_____Chemotherapy
_____Convulsions / Epilepsy
_____Diabetes
_____ Substance Abuse
_____Fatality From Illness
_____High Blood Pressure
_____High Cholesterol
_____HIV / AIDS
_____Interrupted Pregnancies
_____Kidney Disease
_____ Liver Disease
_____Mental Problems
_____Early Heart Attacks
_____Other Heart Disease
_____Substance Abuse
_____Thyroid Disease
_____Tuberculosis
_____Other_____
_____

Do you have any specific concerns you would like to discuss today?

Newborn hospital care
Nutrition
Vaccine schedule
Sleep safety/location
Office hours/after hours contact
Scheduling appointments
Developmental milestones
Family medical history/genetic condition
Preparing siblings
Parenting styles
Other concerns:_____
_____

Home Environment:

Parents (please circle): Married Engaged Live together Single-parent

Occupation: Mom_____ Dad:_____

Pets: No Yes (What kind?)_____

Smokers: No Yes If yes, who_____ If yes, where? Inside Outside

Guns: No Yes Locked away?_____

How did you hear about First Pediatrics? Website Facebook OB Office Friend Other

If other, please specify_____

Do we have your permission to use your name in our "thank you" correspondence? Yes No (please circle)

-------For Office Use Only-------

Physician Notes :

_____

_____

_____