

New Prenatal Patient Questionnaire

DUKE CHILDREN'S CARDIOLOGY OF RALEIGH
Angelo Milazzo, MD, FAAP, FACC
Salim Idriss, MD, PhD, FAAP, FACC
Cathy Robinson, RN

Patient's Name _____

Primary address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Work phone: _____

Cell phone: _____

E-mail: _____

Please list the names of any other adults whom we may contact or with whom we may share information:

Name: _____ Relationship to you: _____ Telephone: _____

Who referred you for today's visit? _____

Primary OB/GYN provider: _____

Name of practice: _____

Location of practice: _____

Are you also seeing a high-risk OB/GYN provider or perinatal specialist? Yes No

What is the reason for today's visit? _____

Have you been evaluated by a pediatric cardiologist before? Yes No

Do you see any other medical specialists? Yes No

If "yes," please list them: _____

How many weeks pregnant are you? _____ Unknown

What was the date of your last menstrual cycle? _____ Unknown

What is your estimated date of delivery? _____ Unknown

Did you use *in vitro* fertilization (IVF) or other fertility treatment during this pregnancy? Yes No

Have you had an amniocentesis or chorionic villous sampling (CVS) during this pregnancy? Yes No

How many previous pregnancies have you had? _____

How many living children do you have? _____

Where do you plan to deliver your baby? _____ Unknown

Please see additional questions on the reverse of this form

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Have you had any of the following symptoms or problems during this pregnancy? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Diabetes
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Preeclampsia
<input type="checkbox"/> Placenta previa

<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Vaginal infection | <input type="checkbox"/> Bleeding
<input type="checkbox"/> Anemia
<input type="checkbox"/> Contractions
<input type="checkbox"/> Preterm labor

<input type="checkbox"/> Use of Lithium
<input type="checkbox"/> Use of alcohol
<input type="checkbox"/> Smoking |
|---|---|

Do you have any medical problems outside of pregnancy? ___ Yes ___ No

If "yes," please explain: _____

Have you ever had surgery? ___ Yes ___ No

If "yes," please explain: _____

Have you ever been hospitalized? ___ Yes ___ No

If "yes," please explain: _____

Have you had a previous child with congenital heart disease? ___ Yes ___ No

Is the father of your baby generally healthy? ___ Yes ___ No

If "no," please explain: _____

Do you work? ___ Yes ___ No

If "yes," what is your occupation? _____

Have you chosen a pediatrician for your baby? ___ Yes ___ No

If so, whom? _____

Do you have any of these problems on either side of your family? Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Children born with heart defects
<input type="checkbox"/> Children born with other birth defects
<input type="checkbox"/> SIDS or infant death under 1 year of age
<input type="checkbox"/> Heart attack under 55 years of age
<input type="checkbox"/> Stroke under 55 years of age
<input type="checkbox"/> Placement of a pacemaker under 55 years of age
<input type="checkbox"/> Death from a cardiac cause under 55 years of age | <input type="checkbox"/> Death from a non-cardiac cause under 55 years of age
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Diabetes, type 1 (requiring insulin)
<input type="checkbox"/> Diabetes, type 2 (not requiring insulin)
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Lupus |
|---|--|

 Signature of patient Date

 Printed name

Thank you for completing this questionnaire