NAME: DATE:

DOB: AGE: REFERRING PHYSICIAN:

FETAL PATIENT HISTORY:

Reason for Visit: _____

Obstetrician: _____

Number of total pregnancies: _____ Number of live births: _____

Gestation age (weeks): _____ Estimated due date: _____

Anticipated delivery location: _____

Do you have any of the following conditions:

Diabetes _____ High blood pressure _____ Lupus erythematous _____

Other Medical Problems: _____

Who lives at home with you? _____

What is your occupation? _____

Do you smoke? _____ Do you drink? _____ Caffeine intake? _____

Current Medications: _____

_____

Allergies: _____

Is there any family history of (in either your family or the father of the baby's family):

Congenital heart disease _____ Arrhythmias _____ Sudden unexplained death _____

Who will be the baby's pediatrician? _____

PATIENT SIGNATURE: _____ Date: _____