

# New Prenatal Patient Questionnaire

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

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

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"/> Bleeding       |
| <input type="checkbox"/> Hypertension                  | <input type="checkbox"/> Anemia         |
| <input type="checkbox"/> Preeclampsia                  | <input type="checkbox"/> Contractions   |
| <input type="checkbox"/> Placenta previa               | <input type="checkbox"/> Preterm labor  |
| <br>   |   |
| <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Use of Lithium |
| <input type="checkbox"/> Urinary tract infection       | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> Vaginal infection             | <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"/> Death from a non-cardiac cause under 55 years of age |
| <input type="checkbox"/> Children born with other birth defects           | <input type="checkbox"/> High blood pressure                                  |
| <input type="checkbox"/> SIDS or infant death under 1 year of age         | <input type="checkbox"/> High cholesterol                                     |
| <input type="checkbox"/> Heart attack under 55 years of age               | <input type="checkbox"/> Diabetes, type 1 (requiring insulin)                 |
| <input type="checkbox"/> Stroke under 55 years of age                     | <input type="checkbox"/> Diabetes, type 2 (not requiring insulin)             |
| <input type="checkbox"/> Placement of a pacemaker under 55 years of age   | <input type="checkbox"/> Thyroid disease                                      |
| <input type="checkbox"/> Death from a cardiac cause under 55 years of age | <input type="checkbox"/> Lupus  |

\_\_\_\_\_  
Signature of patient Date

\_\_\_\_\_  
Printed name

*Thank you for completing this questionnaire*