PEDIATRIC CARDIOLOGY MEDICAL ASSOCIATES
OF SOUTHERN CALIFORNIA

Timothy W. Casarez, MD., FACC
David A. Ferry, MD., FACC
Nancy Kim, MD., FACC
Frederic Leong, MD., FACC
Jeffrey A. Wong, MD., FACC

FETAL PATIENT HISTORY

Patient's Name: ____________________

Date of Birth: ____________________

OB History

When was your last menstrual period? ____________________

When is your due date? ____________________

Including this one, how many times have you been pregnant? ____________________

How many living children do you have? ____________________

Yes No Have you had any miscarriages?
If yes, how many? __________

Yes No Have you ever terminated a pregnancy?
If yes, how many? __________

Yes No Have you been treated for infertility? If yes, please explain below.

____

Yes No Have you had an abnormal AFP test? If yes, please explain below.

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Yes No Have you had an abnormal amniocentesis test? If yes, please explain below.

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Yes No Have you had an abnormal ultrasound? If yes, please explain below.

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FETAL PATIENT HISTORY

Patient's Name: ______________________

Date of Birth: ______________________

Medical History: If yes, please explain.

Yes No Not Sure Do you take any medications? ______________________

Yes No Not Sure Do you have allergies to any medications? ______________________

Yes No Not Sure Do you have high blood pressure? ______________________

Yes No Not Sure Do you have diabetes? ______________________

Yes No Not Sure Just during pregnancy? ______________________

Yes No Not Sure Diet controlled? ______________________

Yes No Not Sure Insulin depedent? ______________________

Yes No Not Sure Do you have Lupus (SLE) or another connective tissue disorder? ______________________

Yes No Not Sure Do you have anti-Ro or La antibodies? ______________________

Social History: If yes, please explain.

Yes No Do you smoke? ______________________

Yes No During this pregnancy? ______________________

Yes No Do you drink alcohol? ______________________

Yes No During this pregnancy? ______________________

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FETAL PATIENT HISTORY

Patient's Name: ______________________________

Date of Birth: ______________________________

Social History cont.: If yes, please explain.

Yes No Have you use illicit drugs?

____

Yes No During this pregnancy?

____

Has anyone in your family had the following: If yes, please explain.

Yes No Child born with a heart problem?

____

Yes No Heart arrhythmia/Pacemaker?

____