PEDIATRIC CARDIOLOGY MEDICAL ASSOCIATES OF SOUTHERN CALIFORNIA

Timothy W. Casarez, MD., FACC
Nancy Kim, MD., FACC
Frederic Leong, MD., FACC
Jeffrey A. Wong, MD., FACC
Hamsika Chandrasekar, MD.

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.

_____

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

_____

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

Clear Y/N

_____

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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?

Clear Y/N

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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?

_____

Clear Y/N

SUBMIT FORM