



Ptarmigan Pediatrics, LLC
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Prenatal Questionnaire

Baby's Last Name: _____ Baby's First Name: _____ Due Date: _____

Mom's Full Name: _____ Mom's Birth Date: _____

Address: _____ Phone #: _____

Dad's Full Name: _____ Dad's Birth Date: _____

Who lives in your home? _____ List any pets: _____

Will you have other help when the baby arrives? (Family & Friends?) _____

Do you know if it's a Boy or Girl (circle)? _____ If it's a boy, are you considering circumcision? Yes / No (circle)

Are you intending to give birth vaginally or by a planned Cesarean? _____

How many children have you given birth to? _____ How many were Cesarean? _____

Have you had problems with any previous pregnancies? _____

Are you expecting any complications during this pregnancy / delivery? _____

What is your OB doctor or midwife's name? _____

Do you intend to breast feed or give formula? _____

If you have other children, did you breast feed them? Yes / No (circle one) If so, for how long? _____

Please list any allergies or diseases you have that you're concerned may effect your baby. _____

Have you used any of the following during this pregnancy: Cigarettes Alcohol "Recreational" Drugs?

Does anyone in your family smoke? Yes / No. If yes, who? _____

Does anyone in your family have:

Asthma? Yes / No please circle: father / mother / brother / sister

Seasonal allergies? Yes / No please circle: father / mother / brother / sister

Food allergies? Yes / No please circle: father / mother / brother / sister

Which foods? _____

Which insurance will cover your child? _____

Are you aware of parental assistance programs such as WIC? _____

Do you have a car seat for your child? Yes / No Do you have any questions for the doctor? _____