Pediatric Cardiology Associates, LLC
Fetal Cardiology Patient Information

*****A full bladder is not required for this study*****

Patient Name:_____ **Date:**_____
Date of Birth: _____ **Age:**_____

Others with you today, with relationship:_____

Why did your doctor order this fetal echocardiogram?_____

Pregnancy dates**:** Expected due date:_____ Weeks pregnant_____ Weight_____

Is this your: _____ Initial visit in our office _____ Follow up visit

If this is a follow up visit, please only note any changes below

Have you seen the Perinatal Center or other specialists for this pregnancy? If so, why?_____
_____

Do you have a return visit scheduled with the specialist for follow up?_____

Do you have any medical problems? _____

How many pregnancies have you had before this? _____

How many children do you have? (List ages) _____

Are you allergic to medications? If yes, please list_____

Current medications _____

Do any of the children have a heart condition? If so, please list child's full name: _____
_____

Do you or the baby's father have any relatives with a heart condition during childhood? If so, please list: _____

Occupation: _____

Check which applies to you: Current smoker _____ Former smoker _____ Never smoker _____

In which hospital are you planning to deliver?_____

Who will be the doctor (or group) delivering your baby?_____

Who will be the baby's pediatrician or family doctor after birth?_____

_____ _____
Signature **Print name**