HEALTH INTAKE FORM: NEW FETAL ECHOCARDIOGRAM

Patient Name: _____ **Date:** _____

Reason/Main Concern For Your Visit Today: _____

Primary obstetrician: **Any other specialist seen during the pregnancy:**

_____ _____

Due Date: _____

Number of previous pregnancies: _____

Number of living children: _____

Any abnormalities on OB ultrasound: _____

Any genetic testing: _____

Current Medications:

Medication Name:	Dose/Amount:	Frequency/times per day:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Medication Name:	Reaction:
_____	_____
_____	_____

Patient Review of Systems:

Does the patient have a history of:

Smoking	Yes	No
Type 1 or 2 Diabetes (before pregnancy)	Yes	No
Autoimmune disease such as Lupus or hypothyroidism	Yes	No

Family History:

Any parent, sibling, grandparent or aunt/uncle:

born with a congenital heart defect?	Yes	No
with a history of an irregular or abnormal heart rhythm?	Yes	No
with Tuberous Sclerosis?	Yes	No
with autoimmune diseases such as Lupus?	Yes	No

Are there any other concerns or questions for today's visit?