

PRENATAL CONSULTATION
CMG/NANSEMOND PEDIATRICS

Date of Consultation: _____

Parent Names Attending Consultation: _____

Address: _____

Phone: _____ (home) _____ (cell) Insurance Carrier: _____

PCP: Dr. Kathryn F. Brooks Dr. Richard L. Curry Dr. Peter C. Grosso

Expected Delivery Date: _____ Mother's Obstetrician: _____

Delivery Hospital: _____

Is there a family history of problems with newborns, such as bleeding or dislocated hips, hearing impairment? Yes No (circle) _____

Is this your first pregnancy? Yes No (circle) _____

Any complications with previous pregnancies? Yes No (circle)

Complications with this pregnancy:

- ❖ Blood Sugar _____
- ❖ Blood Pressure _____
- ❖ Other _____

Was pregnancy planned? Yes _____ No _____

Do you smoke? Yes _____ No _____

Do you drink alcohol? Yes _____ No _____ Take drugs? Yes _____ No _____

Are you pregnant with twins? Yes _____ No _____

Is your baby: Boy Girl (circle) Name of baby (if chosen)? _____

Do you plan on: Breastfeeding _____ Bottle _____

Do you plan to have baby circumcised? Yes _____ No _____

Please list questions you might have for the physician on back of sheet.

How did you hear about our Practice? _____

Thank you for considering CMG/Nansemond Pediatrics to provide care for you new baby.