



**The Austin Diagnostic Children's Clinic** • *adclinic.com*  
Main Clinic – 512/901-4016  
Far West Clinic – 512/531-KIDS (5437)  
South Austin Clinic -512/460-3404

---

## Prenatal Questionnaire

1. Name \_\_\_\_\_  
Mother \_\_\_\_\_ Father \_\_\_\_\_ Last Name \_\_\_\_\_  
Ages: \_\_\_\_\_  
Occupations: \_\_\_\_\_  
Health Problems: \_\_\_\_\_
2. Marital Status: Married ( ) Single ( ) If married, number of years: \_\_\_\_\_  
Children: Yes ( ) No ( ) If yes, ages: \_\_\_\_\_
3. Due Date: \_\_\_\_\_ What type of delivery planned: Natural ( ) C-Section ( )  
Ultrasound determine sex of baby: ( ) Boy ( ) Girl ( ) Unknown
4. Where do you plan to deliver? Hospital ( ) Which one? \_\_\_\_\_  
or Alternate Birthing Center ( )
5. Who is your OB Physician: \_\_\_\_\_
6. Has your pregnancy been healthy? Yes ( ) No ( ) Please explain:  
\_\_\_\_\_  
\_\_\_\_\_
7. Are there any inherited or family diseases we should be aware of?  
\_\_\_\_\_
8. Smoking History: Mother: Y or N Father: Y or N  
Smoked while pregnant: Y or N
9. Other medication/drugs during pregnancy:  
\_\_\_\_\_
- 10: We plan to: ( ) Breastfeed ( ) Bottle feed  
If other children - Did you breastfeed with any previous children: ( ) Yes ( ) No
11. We already have a car seat: ( ) Yes ( ) No
12. Do you have any special questions or concerns?  
\_\_\_\_\_  
\_\_\_\_\_
- 13: Referred by:  
\_\_\_\_\_