FETAL ECHOCARDIOGRAM QUESTIONNAIRE Pediatric Cardiology

	PATIE	NT I	INFORMAT	TION			
Date:							
Name:				DOB:			
Address:							
City:		State:				Zip.:	
Phone Number:		Best Contact Phone Number:					
Married Single Father of (circle one)		of Baby's Name:		Perso	Personal Email:		
	REFERF	RAL	INFORMA	TION			
Obstetrician:							
Address:							
Phone Number:							
Referring Physician (if different	t from OB)):					
Phone Number:							
WHY WERE YOU			FOR A FETA			OGRAM?	
Abnormal ultrasound:		No	□ Yes	_			
Abnormal fetal heart rate:		No	□ Yes				
Abnormal amniocentesis:		No	□ Yes				
Previous child with congenital heart disease:		No	□Yes				
History of maternal/paternal congenital heart disease:		No	□ Yes				
Other family history of congenital heart disease:		No	□ Yes				
Maternal diabetes:		No	□ Yes				
Maternal Lupus:		No	□ Yes				

	MEDICAL HISTORY					
Gestation	nal age:	(weeks/months)	Date of LMP:			
Due Date	2 :					
Where w	vill you deliver?					
List any medications you are currently taking (include vitamins, herbal therapy, and over the counter):						
Do you have any medical conditions that may affect your pregnancy (i.e. blood pressure problems, history of prematurity, etc.)? If yes, please explain.						
Are you having problems with this pregnancy? If yes, please explain.						
Is this your first pregnancy? If no, how many live births have you had?						
Have you had any miscarriages? If yes, how many?						
Have you had any still births? If yes, how many?						
Have yo	u had any general	ultrasounds performed this p	oregnancy? If yes, how many?			
Where w	ere the ultrasoun	ds performed?				
Were there any abnormalities seen on those ultrasounds? If yes, please explain:						
Have you	u had a previous t	fetal echocardiogram? If yes,	how many?			
Were the	ere any abnormali	ties seen on the fetal echo? If	yes, please explain:			