

Are you taking any medications other than prenatal vitamins? Yes No

If yes, please list:

Do you have any chronic medical conditions? Yes No

If yes, please explain:

Have you had any previous hospitalizations? Yes No

If yes, please explain:

Family History (please answer for baby's mother's family and baby's father's family):

Have any family members had the following:

- Born with a congenital heart defect
- Sudden death in an infant, child, or young adult
- Heart rhythm abnormalities
- Genetic syndromes

If yes, please explain:

Social History:

Marital status: Married Single Divorced Widowed

Please list children living with you and their ages:

Total number of persons living with you: _____

Occupation: _____

Highest level of education completed: _____

Smoking history: Never Not during this pregnancy

Yes; list amount/frequency: _____

Recreational drug use: Never Not during this pregnancy

Yes; type/frequency: _____

Alcohol use: Never Not during this pregnancy

Yes; list type/amount/frequency: _____