**Joseph Gali, M.D.**

15000 LOS GATOS BLVD. STE 4

LOS GATOS, CA 95032

(408) 358-3516

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Prenatal Visit with Dr. Gali**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Whom may we thank for referring you to us:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your OB/GYN Dr**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expectant Parents Information:**

Mother’s Last Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Best Daytime Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Do you have any conditions or any health problems which may effect your pregnancy ?**

**YES or NO? (if yes please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you plan to breast feed: \_\_\_\_\_\_\_\_ for how long: \_\_\_\_\_\_\_\_**

**Bottle feed: \_\_\_\_\_\_\_\_**

**Both: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Circumcision**: Yes or No

**Are there any other issues or topics you would like to discuss with Dr. Gali?**

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