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PRENATAL VISIT FORM

MOTHER'S NAME: ______________________________

CONTACT PHONE: ______________________________

PHYSICIAN:

- ☐ Dr. Touraj Shafai
- ☐ Dr. Judith Bedoy
- ☐ Dr. Tannaz Hild
- ☐ Dr. Monica Mustafa

OBSTETRICIAN: ______________________________

HOSPITAL OF DELIVERY: ______________________________

DUE DATE: ______________________________

PREGNANCY COMPLICATIONS (IF ANY): ______________________________

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TOPICS OF INTEREST: ______________________________

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