OBSTETRIX MEDICAL GROUP

OBSTETRIC HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date: _____

Are you currently pregnant? ☐ Yes ☐ No

If yes, what is your due date?: _____

What was the first day of your last menstrual period?: _____

Have you had any problems in the current pregnancy? ☐ Yes ☐ No

If yes, please specify: _____

_____

Prior pregnancies

_____ Number of pregnancies (not including this one)

_____ Number of full term deliveries

_____ Number of preterm deliveries

_____ Number of pregnancies carried past 4 ½ months [20 weeks]

_____ Number of miscarriages [spontaneous]

_____ Number of voluntary abortions

_____ Number of ectopic [tubal] pregnancies

_____ Number of multiple births

_____ Number of living children

Please fill in the table below for all pregnancies, starting with the first, and include all pregnancies, living or deceased.

Year	Weeks Full term=40w ks	Length of Labor	Weight lbs oz	Sex (circle one)	Anesthesia	Type of delivery (i.e. vaginal or C/S)	Hospital
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			

Patient Name: _____ **DOB:** _____

OBSTETRIX MEDICAL GROUP

What medications do you take currently (including prenatal vitamins)?			
Name	Dose	How many times a day?	For how long?

Were you taking any other medications when you became pregnant? ☐ Yes ☐ No If yes, please list:		
Medication	Strength	Dose

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often during the pregnancy _____

How often before pregnancy _____

Do you use illicit drugs ("street drugs")? ☐ Yes ☐ No

__ I have never used drugs. __ I used drugs in the past __ I used drugs before pregnancy. __ I am still using drugs.

Drug	How often

Do you have any medical problems? ☐ Yes ☐ No **If yes, please list below.**

_____

_____

_____

_____

Patient Name: _____ **DOB:** _____

OBSTETRIX MEDICAL GROUP

MEDICAL HISTORY

Do YOU have, or have you had, any of the following conditions:			
☐ Yes	☐ No	☐ Unsure	Unexplained Fever
☐ Yes	☐ No	☐ Unsure	Vision Problems
☐ Yes	☐ No	☐ Unsure	Hearing Loss
☐ Yes	☐ No	☐ Unsure	Ear Infections (other than childhood)
☐ Yes	☐ No	☐ Unsure	Sinus Problems
☐ Yes	☐ No	☐ Unsure	Repeated Nosebleeds
☐ Yes	☐ No	☐ Unsure	Long Term Sore Throat
☐ Yes	☐ No	☐ Unsure	Pneumonia
☐ Yes	☐ No	☐ Unsure	Asthma
☐ Yes	☐ No	☐ Unsure	Close Contact With Persons(s) With Tuberculosis
☐ Yes	☐ No	☐ Unsure	Tuberculosis Vaccine (BCG)
☐ Yes	☐ No	☐ Unsure	Positive Tuberculosis Skin Test
☐ Yes	☐ No	☐ Unsure	Unexplained Cough
☐ Yes	☐ No	☐ Unsure	Unexplained Shortness Of Breath
☐ Yes	☐ No	☐ Unsure	Other Lung Problems
☐ Yes	☐ No	☐ Unsure	Heart Murmur
☐ Yes	☐ No	☐ Unsure	Mitral Valve Prolapse
☐ Yes	☐ No	☐ Unsure	Other Heart Valve Problems
☐ Yes	☐ No	☐ Unsure	Heart Attack
☐ Yes	☐ No	☐ Unsure	Heart Disease
☐ Yes	☐ No	☐ Unsure	Unexplained Chest Pains
☐ Yes	☐ No	☐ Unsure	Unexplained Fainting
☐ Yes	☐ No	☐ Unsure	Irregular Heart Beat
☐ Yes	☐ No	☐ Unsure	Other Heart Problems
☐ Yes	☐ No	☐ Unsure	High Blood Pressure in Pregnancy
☐ Yes	☐ No	☐ Unsure	High Blood Pressure, Other
☐ Yes	☐ No	☐ Unsure	Raynaud's Disease, Raynaud's Phenomenon
☐ Yes	☐ No	☐ Unsure	Poor Blood Circulation
☐ Yes	☐ No	☐ Unsure	Severe Nausea and Vomiting in Pregnancy
☐ Yes	☐ No	☐ Unsure	Severe Nausea and Vomiting Before Pregnancy
☐ Yes	☐ No	☐ Unsure	Intestinal Problems (Irritable Colon, Crohn's Disease, Etc.)
☐ Yes	☐ No	☐ Unsure	Dietary Restriction
☐ Yes	☐ No	☐ Unsure	Unexplained Recurring Diarrhea
☐ Yes	☐ No	☐ Unsure	Constipation Problem
☐ Yes	☐ No	☐ Unsure	Heartburn, Reflux
☐ Yes	☐ No	☐ Unsure	Hepatitis, Yellow Jaundice
☐ Yes	☐ No	☐ Unsure	Liver Problems
☐ Yes	☐ No	☐ Unsure	Bladder or Kidney infections
☐ Yes	☐ No	☐ Unsure	Kidney Stones
☐ Yes	☐ No	☐ Unsure	Problems With Urine
☐ Yes	☐ No	☐ Unsure	Menstrual Problems
☐ Yes	☐ No	☐ Unsure	Infertility, Difficulty Getting Pregnant
☐ Yes	☐ No	☐ Unsure	Vaginal Infections

Patient Name: _____ **DOB:** _____

OBSTETRIX MEDICAL GROUP

(cont.) **Do YOU have, or have you had, any of the following conditions:**			
☐ Yes	☐ No	☐ Unsure	Herpes or a Partner with Herpes
☐ Yes	☐ No	☐ Unsure	Sexually Transmitted Disease
☐ Yes	☐ No	☐ Unsure	Pelvic Inflammatory Disease
☐ Yes	☐ No	☐ Unsure	Gonorrhea
☐ Yes	☐ No	☐ Unsure	Chlamydia
☐ Yes	☐ No	☐ Unsure	Syphilis
☐ Yes	☐ No	☐ Unsure	Genital Warts
☐ Yes	☐ No	☐ Unsure	HIV Infection, AIDS, or a Partner with HIV/AIDS
☐ Yes	☐ No	☐ Unsure	Abnormal PAP Smear(s)
☐ Yes	☐ No	☐ Unsure	Diabetes (High Blood Sugar)
☐ Yes	☐ No	☐ Unsure	Thyroid Problems
☐ Yes	☐ No	☐ Unsure	Other Hormone Problem
☐ Yes	☐ No	☐ Unsure	Epilepsy, Seizure Disorder
☐ Yes	☐ No	☐ Unsure	Unexplained Drowsiness
☐ Yes	☐ No	☐ Unsure	Migraine/Cluster Headaches
☐ Yes	☐ No	☐ Unsure	Other Recurring headaches
☐ Yes	☐ No	☐ Unsure	Depression
☐ Yes	☐ No	☐ Unsure	Panic Attack Disorder
☐ Yes	☐ No	☐ Unsure	Psychiatric/Mental/Emotional/Problems
☐ Yes	☐ No	☐ Unsure	Skin Problems
☐ Yes	☐ No	☐ Unsure	Unexplained Hair Loss
☐ Yes	☐ No	☐ Unsure	Arthritis/Joint Pains
☐ Yes	☐ No	☐ Unsure	Lupus
☐ Yes	☐ No	☐ Unsure	Rheumatic fever
☐ Yes	☐ No	☐ Unsure	Blood Transfusions If Yes, Date _____ Reason _____
☐ Yes	☐ No	☐ Unsure	Bleeding Tendency
☐ Yes	☐ No	☐ Unsure	Blood Clots, Thrombophlebitis
☐ Yes	☐ No	☐ Unsure	Rh Sensitized
			Do you currently smoke? _____ I have never smoked. ___ I smoke every day. Number of packs per day? _____ For how many years? _____ ___ I smoke but not every day. How often do you smoke? _____ ___ I smoked in the past but not currently. When did you quit? _____

Any Previous Surgeries? (include minor or outpatient surgeries such as wisdom tooth removal, D&C, etc.)

Year	Procedure	Hospital

Any allergies to medications? ☐ Yes ☐ No

Medication	Reaction

Any other Problems	

Reviewed by_____ _____ _____

Provider signature **Patient signature** **DOB**

OBSTETRIX MEDICAL GROUP

GENETIC/FAMILY HISTORY

How would you describe your ancestry (check all that apply):

☐ Caucasian (white)	☐ French Canadian	☐ Samoan	☐Vietnamese
☐ African (black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeast Asian
☐ Guamanian	☐ Hawaiian	☐ Asian – East Indian	☐ Unknown Race
☐ Other		☐ Other 2	

Are you and the father of this baby blood relative (example: cousins)? ☐Yes ☐No

What is your occupation? _____

What is the name of the father of this baby? _____

What is the occupation of the father of this baby? _____

What is the age of the father of this baby? _____

How would you describe the ancestry of the father of this baby (check all that apply):

☐ Caucasian (white)	☐ French Canadian	☐ Samoan	☐Vietnamese
☐ African (black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeast Asian
☐Guamanian	☐ Hawaiian	☐ Asian – East Indian	☐ Unknown Race
☐Other		☐ Other 2	

Is the father of this baby your partner? ☐ Yes ☐ No

Comments: _____

_____

_____

Patient Name: _____ **DOB:** _____

Does the father of the baby, or any close relative of yours or the father, have any of the following (if yes, please note who):

Disease/Condition	Yes	No	Relation
1. Thalassemia MCV<80			
2. Neural Tube Defect (Spina Bifida, or Anencephaly)			
3. Congenital Heart Defect			
4. Down Syndrome			
5. Tay-Sachs			
6. Sickle Cell Disease or Trait			
7. Hemophilia or bleeding Problems (Type:)			
8. Muscular Dystrophy			
9. Cystic Fibrosis			
10. Canavan Disease			
11. Mental Retardation/Autism/Learning disorder			
If Yes, Tested for Fragile X			
12. Huntington Chorea			
13. Other inherited genetic or chromosomal disorder			
14. Maternal Metabolic Disorder (i.e. Insulin-Dependent Diabetes, PKU)			
15. Patient or baby's father had a child with birth defects not listed above			
16. Recurrent pregnancy loss, or stillbirth			
17. Blindness or deafness			
18. Bone or skeletal disorder			
19. Breast, ovarian or colon cancer			
20. Kidney disorder			
21. Do any of your parents, siblings, or children have diabetes			
22. Blood clots/stroke			
23. Anything else that seems to run in the family			

Reviewed by_____ _____

Provider signature Patient signature

Patient Name: _____ **DOB:** _____

What is Ultrasound?

Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta, and baby making echoes which a computer converts into detailed images. In essence, an ultrasound is a series of pictures of the baby and organs in the mother's pelvis.

Is Ultrasound safe?

There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either the mother or the baby when ordinary power is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

Does a normal Ultrasound prove that my baby will have no abnormalities?

Ultrasound examinations can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the bay and the baby's organs, but does not give complete information about the function of the baby's organs or tell us that the baby is completely "healthy". Abnormalities of brain function such as mental retardation cannot b e detected by ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities that can appear later in pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal.

Can Ultrasound determine if there are chromosomal abnormalities?

Findings on an ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently the only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cells by amniocentesis, chorionic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities either because of the mother's age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby's chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasound, please do not hesitate to ask the ultrasound technologist, perinatologist, or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

Patient/Guardian Signature	**Date**
Printed Name	**Date of Birth**

Patient Name: _____ **DOB:** _____

OBSTETRIX MEDICAL GROUP

AUTHORIZATION FOR VERBAL RELEASE OF PROTECTED HEALTH INFORMATION AND PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing information in order to foster continuity of care. The release of copies of medical records will require a signed HIPPA-compliant authorization. This permission will be considered on-going until I indicate otherwise, or detail express limitations in writing.

PHI may be released and spoken around the following individuals or additional entities:

NAME	RELATIONSHIP	DATE/INITIALS
_____	_____	_____
_____	_____	_____
_____	_____	_____

The Staff of the Practice has my permission to leave messages concerning treatment (Lab Results, Prescription Information, Appointment Reminders/Times, Call Back Requests) on the following numbers. Additionally, the practice now has the ability to send appointment reminders via "Test Message". Please circle "Text" if preferred. ***standard rates may apply**

(___) _____ -_____ cell / text/ work / home

(___) _____ -_____ cell / text/ work / home

Our Notice of Privacy Practices ("Notice") provides information about 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients. Federal Regulation requires that we give our patients or their representatives notice before signing this acknowledgment. If you have any questions about your rights or our privacy practices, please send an email to Privacy_Officer@Mednax.com or a letter to:

Privacy Officer
MEDNAX Services, Inc.
1301 Concord Terrace
Sunrise, FL 33312

By signing below, you are only acknowledging that you have been provided immediate access to our additional notice as is posted in the office.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Patient's Printed Name

_____ _____

Print Name of Authorized Representative Date

OBSTETRIX MEDICAL GROUP

CONSENT FOR TREATMENT

I hereby give consent to Mednax Medical Group, Inc. dba Atlanta Maternal Fetal Medicine to provide whatever treatment they may deem necessary to me.

_____ _____

Signature of patient or responsible party, if minor Date

Patient Name: _____ _____

PHARMACY INFORMATION

Name of Pharmacy: _____

Address: _____

City: _____ State: _____

Phone Number: _____ Fax Number: _____

OBSTETRIX MEDICAL GROUP

Screening for ZIKA Exposure During Pregnancy

Patient Name: _____ **DOB:** _____

Contact Phone Number: _____ **Today's Date:** _____

Patient

1. Have you or your partner traveled to Miami Dade County, Florida, the Caribbean, South America, Central America, Mexico, Pacific Islands, or other country with Zika activity during the current pregnancy?

   For update list of countries/territories, check:

   http://www.cdc.gov/zika/geo/index.html

   □ **If yes, specify country** _____

   Dates traveled _____

Patient

2. If you or your partner have traveled to any of the countries or regions above, have you had any of the following symptoms either during your travel or within 2 weeks of return from travel?

   Check all that apply:

   _____ Fever
   _____ Maculopapular rash (flat, red area on skin covered with confluent bumps)
   _____ Arthalgia (joint pain)
   _____ Conjunctivitis ("pink eye" or eye infection)

The CDC is recommending against travel to many countries during pregnancy.

If you answered "Yes" to any of the above questions, please discuss this with the physician or nurse practitioner at your visit today.

Because guidelines are changing quickly, please be sure you have provided us with your phone contact information.