FLORIDA PERINATAL ASSOCIATES

Demographics

Patient Information

Last Name	First	M.I.	Social Security Number

Date of Birth	Marital Status	E-mail address
	☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Race	☐ Other _____	

Street Address	Apt #

City	State	Zip	Home Number	Mobile Number
			( )	( )

Employer	Occupation	Work Number
		( )

Do you speak English? ☐ Yes ☐ No

If no, list language: _____

<u>Please Read:</u> There may be times when we need to leave you a phone message containing personal information at the numbers provided above. Please check the numbers where it is permissible for us to leave a message.

☐ Home ☐ Mobile ☐ Work ☐ Other ( ) _____

If there is anyone besides you we are authorized to speak with, please list below or N/A:

Name	Relationship	Phone #'s
		( )
		( )

Emergency Contact

Name	Relationship to Patient

Home Number	Mobile Number	Work Number
( )	( )	( )

Referring Physician

Referring Physician Name

Street Address	Suite #

City	State	Zip	Phone Number
			( )

Patient Name: _____

Insurance

Primary Insurance Information

Are you the Policy Holder? ☐ Yes ☐ No		
Primary Insurance Company	Phone Number ( )	
Policy #	Group #	
Address		
City	State	Zip Code
Policy Holder Name	Relationship to Patient	Date of Birth
Policy Holder Employer		

Secondary Insurance Information (If Any)

Are you the Policy Holder? ☐ Yes ☐ No		
Secondary Insurance Company	Phone Number ( )	
Policy #	Group #	
Address		
City	State	Zip Code
Policy Holder Name (If not the patient)	Relationship to Patient	Date of Birth
Policy Holder Employer		

Please list your mother's maiden name to be used as a password for security purposes: _____

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have had a change in insurance, we are anxious to help you receive your maximum allowable benefits. If you have had a change in insurance, please inform our office staff immediately as this could result in rejection of your claims. In order to expedite the filing of your insurance and provide you with the best possible care, we need your assistance and understanding of our payment policy.

We file your insurance as a courtesy. Co-pays, deductible, and co-insurance payments are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard or Visa. **Returned checks and balances older than 30 days will be subject to additional collection fees and a rebill fee of $10.00.** All charges are your responsibility from the date the services are rendered. Not all services are covered benefit in all contracts. If expenses are not covered for any reason, you are financially responsible for any unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

When an appointment is made in our offices, a specific time is reserved for you to see the doctor. Missed appointments result in a loss of valuable time that could be spent with another high-risk patient in need of treatment and they are very costly to our office. **For this reason, if you fail to keep an office visit you will be charged a fee for a missed appointment.** If an appointment does need to be cancelled or rescheduled for any reason, please notify our office at least 24 hours in advance of the appointed time and no missed appointment fee will be charged. Thank you for your anticipated cooperation.

I understand that I am responsible for payment of my account regardless of the status of an insurance claim and agree to pay for services or treatment rendered to me. If Florida Perinatal Associates is forced to take action for collection of any balance owed by me, either by lawsuit or otherwise, I agree to pay collection costs, including a reasonable attorney's fee and applicable rebill fees. I authorize and request my insurance company to pay Florida Perinatal Associates to provide my medical treatment and care as necessary or advisable. I hereby authorize the office of Florida Perinatal Associates to release any information to my insurance company or another physician, including the diagnosis and treatment or examination rendered to me while under their care.

_____ _____

Signature of Patient/Insured Date

FLORIDA PERINATAL ASSOCIATES

Please Note the Location You Will Be Visiting

Main Location: Tampa
13601 Bruce B. Downs Blvd.
Suite 250
Tampa, FL 33613
(813) 971-6909

Riverview Location
6901 Simmons Loop Road
2nd Floor Suite 208
Riverview, FL 33578
(813) 971-6909

Clearwater Location
2963 Gulf to Bay Blvd
Suite 210
Clearwater, FL 33759
(727) 724-1949

Sarasota Location
5741 Bee Ridge Rd.
Suite 540
Sarasota, FL 34233
(813) 971-6909

Wesley Chapel Location
27509 Cashford Circle
Wesley Chapel, FL 33544
(813) 973-1978

Lakeland Location
808 E. Main Street
Lakeland, FL 33801
(863) 680-3472

IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION

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 exam 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 and frequency 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 examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the baby 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 be detected by ultrasound. Additionally, there are many conditions that evolve over time, appearing normal at the time of the 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 or those abnormalities that can appear later in the 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

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

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 authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to privacy_officer@pediatrix.com or a letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

_____	_____
Signature of Patient or Authorized Representative	Date
_____	_____
Print Name of Patient	Print Name of Authorized Representative

PEDIATRIX MEDICAL GROUP

OBSTETRIX MEDICAL GROUP

The following Notice of Privacy Practice has been adopted by Pediatrix Medical Group, Inc. and its affiliates.

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW OUR PATIENTS OR THEIR LEGAL REPRESENTATIVE(S) CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The use of the words “you” and “your” in the remainder of this document refer to you and/or your child(ren) under the care of any of our physicians.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information “protected health information,” or “PHI” for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy practices at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in the hospitals we serve and in our offices. You can also request a copy of this notice from the contact person listed in Section VI below.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization, and for others, we do not. The following categories describe different ways that we may use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use and disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose PHI will fall into one of the categories.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

We may use and disclose your PHI for the following reasons:

1. For treatment. We may disclose your PHI to provide you with medical treatment or services. Therefore, we may disclose PHI about you to physicians, nurses, technicians, medical students, and other health care personnel who provide you with health care services or who are involved in your care, such as pharmacists, dieticians, genetic counselors, etc.

2. For payment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and to your health plan to get paid for the health care services we provide to you. We may tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3. For health care operations. We may disclose your PHI for our health care operations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care service to you. In order to decide whether or not new treatments are effective, we may combine health information about many patients. We may disclose your PHI to medical students and other health care providers for review and teaching purposes. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

B. Uses and Disclosures for Patient Directories and to Persons Assisting in Your Care.

Generally, we will obtain your verbal agreement before using or disclosing PHI in the following ways. However, in certain circumstances, such as an emergency, we may use and disclose your PHI for these purposes without your agreement.

1. Patient directories. We may include your name, location, general condition, and religious affiliation in a patient directory for use by clergy and visitors who ask for you by name.

2. Disclosures to family, friends or others. We may provide your PHI, including your condition and status, to a family member, friend,

or other person that you indicate is involved in your care or the payment for your health care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that a family member or other person responsible for your care can be notified about your condition, status and location.

C. Certain Other Uses and Disclosures that Do Not Require Your Authorization.

We may use and disclose your PHI without your consent or authorization for the following reasons:

1. Appointment Reminders. We may use and disclose PHI to contact you as a reminder that you have an appointment for tests or treatment.

2. Treatment Alternatives. We may use and disclose PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

3. Health-Related Benefits and Services. We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

4. Research. Under certain circumstances, we may use and disclose your PHI for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. In some cases, research will be conducted through a limited database of PHI that we maintain for research and quality improvement purposes that excludes patient names and other identifying information. All other research projects involving the use of PHI are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with the patients' need for privacy of their PHI. Before we use or disclose PHI for research without your consent, the project will have been approved through this research approval process. We may, however, disclose your PHI to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave our control.

5. As Required By Law. We will disclose your PHI when required to do so by federal, state or local law.

6. To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any such disclosure, however, would be to someone able to help prevent the threat.

7. Organ and Tissue Donation. If you are an organ donor, we may release PHI about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

8. Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

9. Workers' Compensation. We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

10. Public Health Risks. We may disclose PHI about you for public health activities. These activities generally include the following:

a. Preventing or controlling disease, injury or disability;
b. Reporting births and deaths;
c. Reporting child abuse or neglect;
d. Reporting reactions to medications or problems with products;
e. Notifying people of recalls of products they may be using;
f. Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

11. Victims of Abuse, Neglect or Domestic Violence. We may notify the appropriate government authorities if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make such disclosures if you agree or when required or authorized by law.

12. Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

13. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

14. Law Enforcement. We may release your PHI if asked to do so by a law-enforcement official:

a. In response to a court order, subpoena, warrant, summons or similar process;
b. To identify or locate a suspect, fugitive, material witness, or missing person;
c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
d. About a death we believe may be the result of criminal conduct;
e. About criminal conduct at the hospital or in our offices; or
f. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

15. Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

16. National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

17. Protective Services for the President and Others. We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

18. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release may be necessary for a number of reasons, such as:

a. For the institution to provide you with health care;
b. To protect your health and safety or the health and safety of others; or
c. For the safety and security of the correctional institution.

D. All Other Uses and Disclosures Require Your Prior Written Authorization.

In any situation not described in sections III.A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (but only to the extent that we haven't already taken any action relying on the authorization).

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or permitted to make without your authorization (which are generally described in sections III.B(4) through (18) above). To request restrictions, you must make your request in writing to the person listed in Section VI below.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (e.g., your work address rather than your home address) or by alternate means, such as electronic mail ("e-mail") instead of regular mail. Your request must be in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

C. The Right to Review and Get A Copy of Your PHI. In most cases, you have the right to review and get a copy of your PHI that we have, but you must make the request in writing. If we don't have your PHI, but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request, unless we need additional time (up to 30 days more) to respond. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

D. The Right to Get a List of the Disclosures We Have Made.

1. You have the right to get a list of certain instances in which we have disclosed your PHI. The list will not include uses or disclosures to carry out treatment, payment, or health care operations or disclosures directly to or authorized by you. The list also won't include uses and disclosures that are incidental to a permitted use or disclosure, that are part of the limited data set we maintain for research and quality improvement purposes, that are made for national security purposes, to corrections or law enforcement personnel, or that were made before April 14, 2003.

2. We will respond within 60 days of receiving your written request, unless we need additional time (up to 30 days more) to respond. The list we give you will include disclosures made during the time period you specify, provided, however, that the time period may not be longer than six (6) years and may not include dates before April 14, 2003. The list will indicate the date of the disclosure, to who PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same twelve (12) month period, we may charge you

for the costs of providing the additional list(s). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

E. The Right to Correct or Update Your PHI.
1. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing.

2. We will respond to you within 60 days of receiving your request, unless we need additional time (up to 30 days more) to respond. We may deny your request in writing if the PHI:

a. Is accurate and complete;
b. Was not created by us;
c. Is information that we are not required to provide access to; or
d. Is not part of our records.

3. Any written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, you may contact our Privacy Officer: (i) by e-mail at privacy_officer@pediatrix.com; or (ii) by writing to: Privacy Officer, Pediatrix Medical Group, Inc., 1301 Concord Terrace, Sunrise, FL 33323.

VII. EFFECTIVE DATE OF THIS NOTICE

The effective date of this notice is April 14, 2003.

Obstetric History Questionnaire

Patient Name: _____ **Date:** _____

Social Security Number: _____

Are you currently pregnant: ☐ Yes ☐ No

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

What is your due date: _____

Are there any problems with your current pregnancy?

_____

_____

_____

_____

_____

_____

Prior Pregnancies:

_____ **Number of pregnancies continued past 4 ½ months (20 weeks)**

_____ **Number of miscarriages**

_____ **Number of tubal pregnancies (ectopic pregnancies)**

_____ **Number of abortions**

_____ **Number of living children**

Fill information in table below for each pregnancy start with your first one:

Year	Weeks	Labor Length	Birth Wt LB. / OZ.	Sex	Type Of Delivery	Anesthesia	Place

Patient Name: _____

Total Pregnancies	Full Term	Premature	Abortion Induced	Abortion Spontaneous	Ectopics	Multiple Births	Living Children

Comments: _____

Reviewed By _____
Provider Name

OBSTETRIX MEDICAL GROUP

Patient Name: _____
Social Security Number: _____
Date: _____

Genetic / Family History Questionnaire

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

☐ 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 _____	

Are you and the father of this baby blood relatives (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):

☐ 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 _____	

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

Comments: _____

OBSTETRIX MEDICAL GROUP

Patient Name: _____

Genetic / Family History Questionnaire

Do you, the father of this baby, or any close relatives have:

1. Thalassemia (Greek, Mediterranean, or Asian Background) MCV < 80 ☐ Yes ☐ No
2. Neural Tube Defect (Meningomyelocele Spina Bifida, or Anencephaly) ☐ Yes ☐ No
3. Congenital Heart Defect ☐ Yes ☐ No
4. Down Syndrome ☐ Yes ☐ No
5. Tay-Sachs (EG, Jewish, Cajun, French Canadian) ☐ Yes ☐ No
6. Sickle Cell Disease or Trait (African) ☐ Yes ☐ No
7. Hemophilia or Bleeding Problems ☐ Yes ☐ No
8. Muscular Dystrophy ☐ Yes ☐ No
9. Cystic Fibrosis or Canavan Disease ☐ Yes ☐ No
10. Mental Retardation / Autism / Learning Disorder ☐ Yes ☐ No

    If Yes: Tested for Fragile X ☐ Yes ☐ No
11. Huntington Chorea ☐ Yes ☐ No
12. Other Inherited Genetic or Chromosomal Disorder ☐ Yes ☐ No
13. Maternal Metabolic Disorder (EG, Insulin-Dependent Diabetes, PKU) ☐ Yes ☐ No
14. Patient or Baby's Father Had a Child With Birth Defects Not Listed Above ☐ Yes ☐ No
15. Recurrent Pregnancy Loss, or Stillbirth ☐ Yes ☐ No
16. Blindness or Deafness ☐ Yes ☐ No
17. Bone or Skeletal Disorder (Dwarfism) ☐ Yes ☐ No
18. Breast, Ovarian or Colon Cancer ☐ Yes ☐ No
19. Kidney Disorder ☐ Yes ☐ No
20. Do either you or any of your parents, siblings, or children have diabetes ☐ Yes ☐ No
21. Blood Clots / Stroke ☐ Yes ☐ No
22. Have you taken any medications other than PN vitamins since becoming pregnant ☐ Yes ☐ No

    If Yes what type: _____
23. Have you used any street drugs since becoming pregnant ☐ Yes ☐ No

    If Yes what type: _____
24. Have you consumed any alcoholic beverages since becoming pregnant ☐ Yes ☐ No

    If Yes what type: _____
25. Any Other ☐ Yes ☐ No
26. Anything that seems to run in the family ☐ Yes ☐ No

Comments: _____

Reviewed By _____

OBSTETRIX MEDICAL GROUP

Patient Name: _____
Social Security Number: _____
Date: _____

Review Of Systems Questionnaire

Do you or have you taken any medication in the last year:

Medications Taken	Dose	Date Taken

Do you have any known allergies:

Do you currently smoke?

☐ Yes	☐ No	

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 Person(s) With Tuberculosis
☐ Yes	☐ No	☐ Unsure	Tuberculosis Vaccine (BCC)
☐ 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

OBSTETRIX MEDICAL GROUP

Patient Name: _____

☐ 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, Chron's Disease, etc.)
☐ Yes	☐ No	☐ Unsure	Dietary Restrictions
☐ 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
☐ 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 Smears
☐ Yes	☐ No	☐ Unsure	Diabetes (High Blood Sugar)
☐ Yes	☐ No	☐ Unsure	Thyroid Problems
☐ Yes	☐ No	☐ Unsure	Other Hormone Problems
☐ Yes	☐ No	☐ Unsure	Epilepsy, Seizure Disorder

OBSTETRIX MEDICAL GROUP

Patient Name: _____

☐ 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
☐ Yes	☐ No	☐ Unsure	Bleeding Tendency
☐ Yes	☐ No	☐ Unsure	Blood Clots, Thrombophlebitis
☐ Yes	☐ No	☐ Unsure	Rh Sensitized
☐ Yes	☐ No	☐ Unsure	Any Past Surgeries (if yes please list below)
☐ Yes	☐ No	☐ Unsure	Any Known Allergies

Past Surgeries:

Name of operation	Type of Anesthesia	Hospital	Surgeon

Comments: