ATTENTION PATIENTS

Given recent updates by the CDC and Local Hospitals about the prevention and spread of influenzas, we are enforcing the recommended policy of limiting the number of guests accompanying the patient in our offices. We ask that no more than **1-2 persons** accompany each patient for the ultrasound exam. **Child counts as guest.** All children under the age of **6 years old** must be supervised by an adult.

***Pregnant women are at an increased risk for severe complications and death from the infection of influenza/H1N1** (CDC)* and here in the office we must be proactive in preventing the possible exposure of infection.

We also ask that all patients **advise the front office** if **you or your guest** have **Flu-like symptoms**, these include:

Fever **Cough** **Sore Throat** **Runny or Stuffy Nose**

Muscle/Body Aches **Headaches** **Chills** **Fatigue**

Diarrhea **Vomiting**

We have tried to ensure that all patients have been informed of this policy prior to your first visit; however, if you have not, we apologize for any inconvenience but must do all we can to **ensure the health and safety of our patients -** especially here in the office.

Our staff will provide information to you about where to go for, flu shots as well as H1N1 vaccines and others as they become available. Generally, these vaccines will be given by your PCP or Obstetrician. Local **Urgent Care Centers** are also providing seasonal flu shots for $25. More information about influenza and related pregnancy concerns can be found at:

http://www.cdc.gov/flu/protect/vaccine/pregnant.htm

We apologize for any inconvenience this may cause and truly understand what an exciting time this is for you and your family. **Please remember that our primary concern here at MFDC is the provision of high quality healthcare and 100% of our attention to you and your unborn child.**

Patient Signature_____ DOB_____
Today's Date: _____

Thank you,
Maternal Fetal Diagnostic Center

Revised: 12/2010

Maternal Fetal Diagnostic Center of Atlanta, Inc

OBSTETRIX MEDICAL GROUP

Authorization to Release Protected Health Information and Patient Acknowledgment 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 "Text Message", please circle "text" if prefer. ***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 or 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@Pediatrix.com or a letter to:

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

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

_____ _____
Signature of Patient Date of Birth

_____ _____
Print Name of Patient Today's Date

Patient Name _____ Today's Date _____

Birthdate ___/___/____ Reason for today's visit _____

Menstrual History

When was the first day of your last normal period? _____

What due date is your doctor using? _____
Is your due date based on: Last period date **or** ultrasound

Any problems with this pregnancy? Y N If yes, please describe:

_____

_____

Previous Pregnancies

How many times have you been pregnant, including this pregnancy, miscarriages, & abortions? _____
How many babies were born after 37 weeks? _____
How many babies were born before 37 weeks but after 20 weeks? _____
How many miscarriages have you had? _____
How many terminations (abortions) have you had? _____
How many children are living? _____
How many Ectopic pregnancies? _____

Please provide ALL previous pregnancy information (including miscarriages and terminations)

Date (Month/year)	How far along were you?	Baby's birth Weight	Vaginal or C-section	Complications

Reviewed by : _____

Patient Name _____ Birthdate ___/___/____

Genetic / Family History

Certain genetic problems are more common in certain ethnic groups. Please circle your ethnic background:

White (non Hispanic) Black (non Hispanic) Hispanic
American Indian /Alaskan Native Asian/Pacific Islander Other _____

Please circle ethnic background for the father of this baby:

White (non Hispanic) Black (non Hispanic) Hispanic
American Indian /Alaskan Native Asian/Pacific Islander Other _____

Are you and the baby's father blood relatives (for example, cousins)? Y or N

Do you, the father of this baby, or any close relatives have any of the following conditions?

Thalassemia (Greek, Mediterranean, or Asian background)	YES	NO
Neural Tube Defects (Spina Bifida or Anencephaly)	YES	NO
Congenital Heart Defects	YES	NO
Down Syndrome	YES	NO
Tay-Sachs (Jewish, Cajun, French Canadian)	YES	NO
Sickle Cell Disease or Trait	YES	NO
Hemophilia or Bleeding Problems	YES	NO
Muscular Dystrophy	YES	NO
Cystic Fibrosis	YES	NO
Mental Retardation/Autism If yes, tested for Fragile X ? Y or N	YES	NO
Huntington Chorea	YES	NO
Other Inherited Genetic or Chromosomal Disorder	YES	NO
Maternal Metabolic Disorder (Diabetes, PKU)	YES	NO
Patient or Baby's Father: previous child with other birth defect not listed above	YES	NO
Recurrent Pregnancy Loss or Stillbirth	YES	NO
Blindness or Deafness	YES	NO
Bone or Skeletal Disorder (Dwarfism)	YES	NO
Breast, Ovarian Cancer	YES	NO
Kidney Disorder	YES	NO
Family history Diabetes	YES	NO
Blood Clots / Stroke	YES	NO
Taken medication with this pregnancy?	YES	NO
Used any street drugs with this pregnancy?	YES	NO
Consumed alcohol with this pregnancy?	YES	NO
Any other conditions that run in the family?	YES	NO

If Yes, Please Explain:

_____
_____
_____
_____
_____

Reviewed by: _____

Patient Name _____ Birthdate ___/___/____

Please list medications with this pregnancy.

Medication name and amount	Date taken

Any Known Allergies? Please list or write N/A if not applicable.

Please list Immunizations with this pregnancy. (Flu shot, pneumonia, TDap, etc.)

Health Habits (please circle if you use any of the following and indicate amount):

Caffeine ___ cups/day
Tobacco ___ cigs/pack per day for ____ years
Drugs _____
Other _____

Occupation: _____
Does your occupation expose you to: Stress Heavy lifting Chemical X-ray/radiation Other _____

Pharmacy Information:

Pharmacy Name: _____

Address: _____

Phone: _____

Reviewed by: _____

Patient Name _____ Birthdate ___/___/____

ROS Questionnaire

Have you in the past year or do you currently have any of the following conditions?

Fever	Yes	No
Vision problems	Yes	No
Hearing loss	Yes	No
Ear infections	Yes	No
Sinus problems	Yes	No
Repeated nosebleeds	Yes	No
Long-term sore throat	Yes	No
Pneumonia	Yes	No
Asthma	Yes	No
Close contact with person with TB	Yes	No
TB vaccine	Yes	No
Positive TB skin test	Yes	No
Unexplained cough	Yes	No
Shortness of breath	Yes	No
Other lung problems	Yes	No
Heart murmur	Yes	No
Mitral valve prolapse	Yes	No
Other heart valve problems	Yes	No
Heart attack	Yes	No
Heart disease	Yes	No
Unexplained chest pains	Yes	No
Unexplained fainting	Yes	No
Irregular heart beat	Yes	No
Other heart problems	Yes	No
High blood pressure, in pregnancy	Yes	No
High blood pressure, other	Yes	No
Raynaud's disease	Yes	No
Poor blood circulation	Yes	No
Severe nausea and vomiting, in pregnancy	Yes	No
Severe nausea and vomiting, before pregnancy	Yes	No
Intestinal problems (IBS, Crohn's disease, etc.)	Yes	No
Dietary restrictions	Yes	No
Unexplained recurring diarrhea	Yes	No
Constipation	Yes	No
Heartburn/Reflux	Yes	No
Hepatitis / Jaundice	Yes	No
Liver problems	Yes	No
Bladder or kidney infections	Yes	No
Kidney stones	Yes	No
Problems with urine	Yes	No
Menstrual problems	Yes	No
Infertility / Difficulty getting pregnant	Yes	No
Vaginal infections	Yes	No
Herpes or partner with herpes	Yes	No
Sexually transmitted disease	Yes	No
Pelvic inflammatory disease	Yes	No
Gonorrhea	Yes	No
Chlamydia	Yes	No
Syphilis	Yes	No
Genital warts	Yes	No
HIV, AIDS or a partner with HIV / AIDS	Yes	No
Abnormal pap smear	Yes	No
Diabetes	Yes	No

Patient Name _____ Birthdate ___/___/____

ROS Questionnaire - Continued

Thyroid problems	Yes	No
Other hormone problems	Yes	No
Seizure disorder / Epilepsy	Yes	No
Unexplained drowsiness	Yes	No
Migraine headaches	Yes	No
Other recurring headaches	Yes	No
Depression	Yes	No
Panic attacks / panic disorder	Yes	No
Psychiatric / mental / emotional problems	Yes	No
Skin problems	Yes	No
Unexplained hair loss	Yes	No
Arthritis / joint pain	Yes	No
Lupus	Yes	No
Rheumatic fever	Yes	No
Blood transfusions	Yes	No
Bleeding tendency	Yes	No
Blood clots / thrombophlebitis	Yes	No
Rh Senstitized	Yes	No
Past surgeries, if yes list below	Yes	No
Any known Allergies	Yes	No

Past Surgeries: _____

_____

If yes, please explain: _____

_____

_____

_____

_____

Reviewed by: _____