First Point of Contact Screening

Patient Name____________________________________ Date__________________

Please print full legal name

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? YES NO

If yes, please circle the symptoms you have now, or have had, over the past seven days?

- fever
- night sweats
- sneezing or runny nose
- severe headache
- stiff neck
- muscle or joint pain (circle one or both)
- new rashes or open sores on your skin or in your mouth
- redness, swelling, or discharge of your eyes (pink eye)
- unexplained bleeding
- vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? YES NO

If yes, please list where: ________________________________________________

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? YES NO

If yes, please list where: ________________________________________________

Thank you for your help and support in caring for our patients and community.

**TO BE FILLED OUT BY OFFICE STAFF**

Reviewed by: __________________________________________________________

Action taken:

☐ No action taken
☐ Isolate
☐ Cough/ hand washing etiquette provided
☐ Mark provided
☐ PM/ Lead clinical provided

Thank you for trusting us with your healthcare! Revised: 01/11/17
On behalf of the team here at Mountain Vista OB/GYN & Midwifery we want to welcome you to the practice! We understand you have a variety of choices in your healthcare and we want to thank you for choosing our Practice for your OB/GYN needs!

Name: ___________________________________________    Date: ___________________

Who will be taking care of you today?

- Amita Kumar, M.D.
- Lori Lindsay, M.D.
- Alex Marcotty, M.D.
- Kenneth Moss, M.D.
- Andrew Ross, M.D.
- Elizabeth Newell, M.D.
- Jennifer Wilson, M.D.
- Lauren Linden, CNM
- Shana Martin, CNM
- Mary Wilterdink, CNM
- Joan Girard, NP
- Shelbie Paul, NP
- Diane Torres, NP
- Abbie Wegert, NP

How did you hear about our practice?

- Referring provider (First and last name) _____________
- Family/friends
- Healthgrades.com
- Insurance (Physician directory)
- Mountain vista website
- Direct mailer
- Social Media (facebook, blog, twitter) _____________
- Search engine (specify) _____________
- Vitals.com
- Yelp.com
- Google places
- Other _____________
-Received postcard in the mail

To find out more information visit our website at:

http://MountainVistaOBGYNMidwifery.com

Thank you for taking the time to let us know how you heard about us.
General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________  ______________________________
Signature of Patient or Personal Representative  Date

______________________________  ______________________________
Printed Name of Patient or Personal Representative  Relationship to Patient

______________________________  ______________________________
Printed Name of Witness  Employee Job Title

______________________________  ______________________________
Signature of Witness  Date

Revised 1/11/17
Patient Responsibility Policy

Thank you for choosing Mountain Vista OB/GYN and Midwifery for your OB/GYN needs. In order to achieve our goal in providing and maintaining a good physician-patient relationship we believe it is important to have solid policies in place. The policy below is designed to help provide our patients with high quality, cost-effective and timely health care. We ask that you carefully read and sign the following expectations prior to your visit.

A 24 hour notice is expected for all appointment cancellations and reschedules.
- If you fail to notify us of a cancellation or reschedule your appointment, it will result in a “No-Show/ No-Call”.

Patients with repeat “No-show/ No-Call’s” are subject to review with possible discharge from the practice.

Patients are expected to arrive 15 min. prior to their scheduled appointment time to accommodate the check-in process.
- If you fail to arrive 15 min. prior to your appointment you may be asked to reschedule.

Upon arrival, please sign in at the front desk and present complete insurance information, which includes:
- Current health insurance cards and proper picture ID.
- You will be asked to present both of these items at each visit for proper identification.
- If you fail to provide complete or current insurance information we may not be able to accurately file your claim(s) and you will be responsible for full payment until accurate information is submitted to our office.

Co-payments are expected to be paid at each visit if required by your insurance plan.
It is the patient’s responsibility to know their healthcare benefits and coverage limitations.
- Any services determined NOT covered by your insurance plan will be the patient’s responsibility to pay.

A 35% discount is provided to patients without health care coverage or if we do not participate with your health plan.

I, the undersigned, have read and understand the Mountain Vista OB/GYN and Midwifery Patient Responsibility Policy above. I agree to comply and accept the terms and responsibility to the policy as outlined above. I agree to pay for all services rendered NOT covered by my insurance plan and to notify the office should there be any changes to my health insurance coverage.

_____________________________________________________
Patient Name (print)

__________________________________________________________________ _________________________________
Patient Signature (or Responsible Party)          Date

Patient Privacy Policy

In an effort to protect your privacy, our practice standard does not allow sharing of medical information with anyone except the patient or legal guardian or for messages to be left on voice mail unless permission is given.
If you would like to grant permission please indicate below.

Approved phone numbers for detailed voice mail messages:

My home phone: ____________________________
OTHER: ____________________________
My cell phone: ____________________________
My Spouses phone: ____________________________
My work phone: ____________________________
My Spouses Name: ____________________________

I, the undersigned, give permission to the office of Mountain Vista OB/GYN and Midwifery to leave a phone message regarding my medical care on the numbers listed above, including the voice mail associated with that number.

__________________________________________________________________ _________________________________
Patient Signature (or Responsible Party)          Date

Revised 01/11/2017
Dear Patient,

We want to congratulate you on your pregnancy!

We understand you have many options in Health Care and are so happy that you have chosen us to share this exciting time with you.

Mountain Vista OB/GYN & Midwifery recognizes that early information about potential serious problems during your pregnancy is something very valuable for soon-to-be parents. And, is why we offer non-invasive Genetic Screenings that are recommended by ACOG (American College of Obstetricians and Gynecologists) to all of our pregnant patients.

Non-invasive Genetic Screenings have been developed primarily to look for trisomy genetic abnormalities for which an extra chromosome may be present. Trisomy abnormalities tend to be sporadic and generally cannot be predicted by personal or family history. The most common trisomy disorders that are screened for are Trisomy 21 (Down syndrome), Trisomy 18 (Edwards syndrome), and Trisomy 13 (Patau syndrome).

The advantage of Non-invasive testing is that no harm can result to either the mother or the baby. The disadvantage is that it is not 100% precise. Values are given as an odds ratio, comparing your test values against those of large numbers of patients. Screening tests are done during different trimesters of pregnancy and are entirely optional.

Your health care provider will discuss all of the testing options with you and depending on your personal or family history and individual risk assessment obtained at your New OB visit will help determine which Genetic Screening is best for you and your baby.

Thank you,

Mountain Vista OB/GYN & Midwifery

Revised 01/11/2017
**Genetic Screening and Testing Options**

**First Trimester Screening**
This test must be completed between 11 weeks/3 days and 13 weeks/6 days gestation.
This is a two-part test that begins with a Nuchal Translucency ultrasound that measures the thickness of the skin on the back of the baby's neck and a maternal blood finger stick.
Together, the two-part testing has 92% sensitive.
- If the results are normal, a second blood draw is done between 15-20 weeks gestation. Which measures a protein produced by the fetus called AFP (Alpha Feta Protein). This calculates the risk of neural tube defects which results from incomplete development of the brain, spinal cord, or their coverings.
- If the results are abnormal, an amniocentesis may be warranted.

**MaterniT21**
This test is drawn any time after 10 weeks gestation and involves a maternal blood draw.
It is offered to any woman with increased factors including Advanced Maternal Age, personal or family history of chromosomal abnormalities, fetal ultrasound abnormalities suggestive of aneuploidy or positive serum screening test.

**Penta Screen**
This test is drawn between 15 -20 weeks gestation and involves a maternal blood draw.
It is an option for patients who are past 13 weeks/3 days gestation or who have declined the First Trimester Screening.
This testing has 85% sensitivity.

___

*(For Provider ONLY)*
The Genetic Screening recommended to you by your Provider is:
- [ ] First Trimester Screening
- [ ] MaterniT21
- [ ] Penta Screen

Provider Signature: ___________________________________________ Date: ___________________________

___

*(For Patient ONLY)*
- [ ] Decline
- [ ] Disagree, I would like: ___________________________
- [ ] Agree

I, ____________________________________________...with the Genetic Screening recommended by my Provider.
- I understand the decision to have a Genetic Screening is completely optional and my choice.
- I understand that if I wish to have these tests done, my insurance may not cover the cost of testing and I am responsible if the insurance does not cover.

I have read the information provided to me and have had my questions have been answered to my satisfaction.

Patient Signature: ___________________________________________ Date: ___________________________

Revised 1/11/17
# Patient Review of Systems

Name: ____________________________________________ Referring Provider: __________________________________

DOB: _____________________________________________ Other Physician/Specialist: ____________________________

Occupation: _______________________________________ Marital Status: □ Married □ Single □ Divorced □ Widowed

Highest level of school completed: □ High school □ College □ Graduate Degree □ other: ____________________________

*Please answer all questions if applicable. All information will be kept confidential.

Are you currently experiencing any of the following? (Please circle Yes or No)

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Resp./Pulmonology</th>
<th>Gynecology</th>
<th>Psychology</th>
<th>Hem/Lymph</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Fever</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Weight loss</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Weight gain</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Skin &amp; Breast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast discharge</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lump in breast(s)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pain in breast(s)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Skin lesions</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dry skin</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in vision</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ringing in ears</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Congestion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Headache</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications and Vitamins:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergies to Medications?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Review with patient. Provider Signature_______________________________________________________________

Revised 01/11/2017
**New Patient Health History**

Name: ____________________________________________ Referring Provider: ____________________________

DOB: _____________________________________________ Other Physician/Specialist: ____________________________

Occupation: _______________________________________ Marital Status: □ Married □ Single □ Divorced □ Widowed

Highest level of school completed: □ High school □ College □ Graduate Degree □ other: ____________________

*Please answer all questions if applicable. All information will be kept confidential*

**Do you have any allergies?** □ No □ Yes (please list below)

**Are you currently taking any Prescription or Over-the-counter medications, herbal remedies or vitamins?** □ No □ Yes (please list below)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose (total mg)</th>
<th>How many times per day?</th>
<th>When do you take it? (Morning, afternoon, night)</th>
<th>Name of prescribing doctor?</th>
<th>How do you take the medication?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Oral □ Injection □ Dermal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Oral □ Injection □ Dermal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Oral □ Injection □ Dermal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Oral □ Injection □ Dermal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Oral □ Injection □ Dermal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Oral □ Injection □ Dermal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Personal Medical History:** Have you ever had any of the following?

<table>
<thead>
<tr>
<th>Illness</th>
<th>(Circle Yes or No)</th>
<th>Illness</th>
<th>(Circle Yes of No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>No Yes</td>
<td>Eating Disorder</td>
<td>No Yes</td>
</tr>
<tr>
<td>Arthritis/joint pain</td>
<td>No Yes</td>
<td>Glaucoma</td>
<td>No Yes</td>
</tr>
<tr>
<td>Asthma</td>
<td>No Yes</td>
<td>High Blood Pressure</td>
<td>No Yes</td>
</tr>
<tr>
<td>Bowel trouble</td>
<td>No Yes</td>
<td>Kidney Disease</td>
<td>No Yes</td>
</tr>
<tr>
<td>Cancer</td>
<td>No Yes</td>
<td>Pneumonia</td>
<td>No Yes</td>
</tr>
<tr>
<td>Chronic Lung Disease</td>
<td>No Yes</td>
<td>Seizures/epilepsy</td>
<td>No Yes</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>No Yes</td>
<td>Stroke</td>
<td>No Yes</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>No Yes</td>
<td>Thyroid Disease</td>
<td>No Yes</td>
</tr>
<tr>
<td>Depression/anxiety</td>
<td>No Yes</td>
<td>Tuberculosis</td>
<td>No Yes</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No Yes</td>
<td>Other: ______________</td>
<td>No Yes</td>
</tr>
<tr>
<td>DVT’s/Clotting Disorder</td>
<td>No Yes</td>
<td>Other: ______________</td>
<td>No Yes</td>
</tr>
</tbody>
</table>

**GYN History**

<table>
<thead>
<tr>
<th>Date of your last Pap?</th>
<th>Have you ever had an abnormal Pap?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Yes</td>
</tr>
</tbody>
</table>

-If yes, when?

-If yes, is your partner: □ Male □ Female □ Both

**Sexual History**

Are you sexually active? □ No □ Yes

If yes, is your partner: □ Male □ Female □ Both

Lifetime sexual partners: #

How many sexual partners in the last year?

Date last period began: / /

How many days between periods:

- If yes, what?

**Contraceptive History** □ N/A

Current method of contraception: (check box below)

□ None □ Natural Family Planning □ Condoms
□ Diaphragm □ Nexplanon □ Depo-Provera □ IUD
□ Permanent Sterilization □ Pills □ Nuva Ring
□ Other, which? ____________________________

How long have you been using this method? ____________________________

If you are not having menstrual periods, is it due to:

□ Hysterectomy □ Pregnancy □ Menopause
□ Other: ____________________________

If Menopausal, do you experience any of the following:

□ Hot flashes □ Night sweats □ Insomnia □ Vaginal dryness
□ other: ____________________________

Are you having problems with this method? □ No □ Yes

-If yes, explain:

Do you want contraceptives now? □ No □ Yes
**Are you taking hormones?**  
- No  
- Yes  
  - If yes, what type?  

**Do you experience any involuntary urine leakage?**  
- No  
- Yes  

**Have you had a colorectal cancer screening?**  
- No  
- Yes  
  - If yes, when was your last?  

**Have you ever had a Mammogram?**  
- No  
- Yes  
  - If yes, when was your last?  

**OB/Pregnancy History**  
- □ None  
- Total number of Pregnancies:  
- Total number of Living children:  
  - # Miscarriages:  
  - # Live births:  
  - # Abortions:  
  - # Still births:  
  - # Ectopic:  
  - # C-sections:  

(List pregnancies below)

<table>
<thead>
<tr>
<th>Birth year</th>
<th>Sex</th>
<th>Wt. of Baby</th>
<th>Hrs in labor</th>
<th>Wks. gestation</th>
<th>Vag. / C/S</th>
<th>Anesthesia used</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Surgeries/Hospitalizations**  
(Please list any surgeries or hospitalizations below, if not leave blank)

<table>
<thead>
<tr>
<th>Date</th>
<th>Surgery/Hospitalization</th>
<th>Date</th>
<th>Surgery/Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Family History**  
Has anyone in your family ever had any of the following?

<table>
<thead>
<tr>
<th>Illness</th>
<th>(Circle Yes or No)</th>
<th>If yes, who? (which maternal or paternal family member)</th>
<th>Illness</th>
<th>(Circle Yes or No)</th>
<th>If yes, who? (which maternal or paternal family member)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>No</td>
<td>Yes</td>
<td>Eating Disorder</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Arthritis/joint pain</td>
<td>No</td>
<td>Yes</td>
<td>Glaucoma</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Asthma</td>
<td>No</td>
<td>Yes</td>
<td>High Blood Pressure</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Bowel trouble</td>
<td>No</td>
<td>Yes</td>
<td>Kidney Disease</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Cancer</td>
<td>No</td>
<td>Yes</td>
<td>Pneumonia</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>- If yes, type of cancer:</td>
<td></td>
<td></td>
<td>Rheumatic Fever</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Chronic Lung Disease</td>
<td>No</td>
<td>Yes</td>
<td>Seizures/epilepsy</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>No</td>
<td>Yes</td>
<td>Stroke</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>No</td>
<td>Yes</td>
<td>Thyroid Disease</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Depression/anxiety</td>
<td>No</td>
<td>Yes</td>
<td>Tuberculosis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No</td>
<td>Yes</td>
<td>Other: __________</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>DVT’s/Clotting Disorder</td>
<td>No</td>
<td>Yes</td>
<td>Other: __________</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Social History**

<table>
<thead>
<tr>
<th>Do you drink alcohol?</th>
<th>- No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If yes, # drinks/day:</td>
<td></td>
<td></td>
</tr>
<tr>
<td># drinks/week:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you ever smoked cigarettes?</th>
<th>- No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Currently</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>- Packs/day:</td>
<td>__________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you exercise regularly?</th>
<th>- No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If yes, #/week:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you use recreational drugs?</th>
<th>- No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If yes, what type:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you drink caffeine?</th>
<th>- No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If yes, # drinks/wk?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you on a special diet?</th>
<th>- No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If yes, what?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 1/11/2017
OB Health History Intake

Patient Name: _________________________________________
DOB: ____________________________________
Will you be 35 or older when the baby is born?  No Yes
Do you have a cat that lives with you?  No Yes

Infection History
Do you or your partner have a history of Genital Herpes?  No Yes, if so who: ____________________
Do you or your partner have a history of sexually transmitted Disease? (Chlamydia, Gonorrhea, HPV, HIV Syphilis) No Yes, if so who: ____________________
Do you or your partner have a history of Hepatitis B or C?  No Yes, if so who: ____________________
Have you been exposed to dangerous drugs, chemicals, Radiation or infection?  No Yes, if so who: ____________________

Family History
What major health problems run in your family?
• Diabetes No Yes, if so who: ____________________
• Heart Disease No Yes, if so who: ____________________
• Hypertension No Yes, if so who: ____________________
• Blood Clots No Yes, if so who: ____________________
• Liver Disease No Yes, if so who: ____________________
• Thyroid Disease No Yes, if so who: ____________________
• Kidney Disease No Yes, if so who: ____________________
• Mental Health Problems No Yes, if so who: ____________________
• Cancer No Yes, if so who: ____________________

Genetic History
Is there anyone in your family or your baby’s father’s family, with any of the following genetic problems? (Siblings, parents, grandparents)
• Down Syndrome (Mongolism) No Yes, if so who: ____________________
• Spina Bifida or Meningomyeoecele (open Spine) No Yes, if so who: ____________________
• Hemophilia or other blood abnormalities No Yes, if so who: ____________________
• Muscular Dystrophy No Yes, if so who: ____________________
• Thalassemia No Yes, if so who: ____________________
• Cystic Fibrosis No Yes, if so who: ____________________
• Huntington’s Disease No Yes, if so who: ____________________
• Sickle Cell Disease (African) No Yes, if so who: ____________________
• Tay-sachs or Canavan (Ashkanazi Jewish) No Yes, if so who: ____________________
• Mental retardation or other types No Yes, if so who: ____________________
• Babies born with heart or kidney problems No Yes, if so who: ____________________
• Frequent miscarriages or stillbirths No Yes, if so who: ____________________
• Child with birth defects No Yes, if so who: ____________________
• Other genetic problems: ____________________________________________________________

Signature: ____________________________________________ Date: ___________________________
Our practice is now on EMR and would like to web-enable you to our patient portal. You would be able to obtain your records online, see your lab/test results and send/receive secure messages to/from your provider. Do you consent to be web-enabled?  YES ________  NO________

*E-Mail Address:___________________________________ _________________________________________________________

PATIENT INFORMATION (Please Print)

<table>
<thead>
<tr>
<th>Patient’s Name (Last)______________________________</th>
<th>(First)______________________________</th>
<th>(MI)______________</th>
<th>Previous Name:______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:__________________________</td>
<td>Sex:  □ F – Female □ M – Male □ Transgender</td>
<td>Address:__________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>City:_________________________________________</td>
<td>State:__________________________</td>
<td>ZIP:__________________________</td>
<td></td>
</tr>
<tr>
<td>Home Phone:__________________________</td>
<td>Cell No.__________________________</td>
<td>SSN:__________________________</td>
<td></td>
</tr>
<tr>
<td>*E-Mail Address:___________________________________ _________________________________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employment Name: _______________________________________________Work Phone: ____________________________________

Employment Status: □ 1 - Full-Time □ 2 - Part-Time □ 3 - Not Employed □ 4 - Self-Employed □ 5 – Retired □ 6 - Active Military

Student Status: □ F - Full-Time Student □ P - Part-Time Student □ N – Not a Student

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Legally Separated Partner

Race: □ American Indian or Alaska Native □ Asian Native □ Hawaiian or Other Pacific Islander □ Black or African American □ White □ Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Language: □ English □ Spanish □ Indian □ Japanese □ Chinese □ Korean □ French □ German □ Russian □ Other ____________

Primary Care Physician (PCP): __________________________________________ Phone: ___________________________________

Pharmacy: ___________________________________________________________Pharmacy Phone: ____________________________

Emergency Contact: Last Name: ____________________________________ First Name: ____________________________

Phone Number: _________________________________________________ Relationship to Patient: ____________________________

RESPONSIBLE PARTY INFORMATION – ONLY IF PATIENT IS A MINOR (Or Power of Attorney relationship)

Check here if information is same as patient □ Responsible Party (If minor): □ Another Patient □ Guarantor

Responsible Party Name (Last) ____________________________________ (First) __________________________ (MI) ___________

DOB: ____________________________ Home Phone: ____________________________ Cell No: ____________________________

Address:_________________________________________________________Apt: ____________________________ |

City:_________________________________________ State:__________________________ ZIP:__________________________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company: __________________________________________ Phone: _________________________________________

Subscriber ID (Policy Number): ____________________________ Group ID: ____________________________

Name of Policy Holder: __________________________________________ Patient Relationship to Policy holder: ____________________________

Policy Holder’s DOB: ________________ Effective Date: ________________ Policy Holder’s SS#: ________________

SECONDARY INSURANCE INFORMATION (If Medicare, please provide reason) (provide your insurance card to the front desk at check-in)

Insurance Company: __________________________________________ Phone: _________________________________________

Subscriber ID (Policy Number): ____________________________ Group ID: ____________________________

Name of Policy Holder: __________________________________________ Patient Relationship to Policy holder: ____________________________

Policy Holder’s DOB: ________________ Effective Date: ________________ Policy Holder’s SS#: ________________

Medicare Secondary reason: □ Working Aged Beneficiary/Spouse □ Disabled Beneficiary under age □ Other liability

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature: __________________________________________ Date: ____________________________

Revised 1/11/17