WELLSTAR
Medical Group
Cobb Gynecologists

Patient History Form: Obstetrics

Patient Name _____ DOB _____

Female History

Last Menstrual Period: _____ ☐ Definite ☐ Unknown ☐ Approximate

Monthly menses? ☐ Yes ☐ No How far apart are periods: _____

Normal amount/duration? ☐ Yes ☐ No Age of first period: _____

On BCP at conception? ☐ Yes ☐ No Pregnancy Test Date: _____

Prior Menses Date: _____

How many pregnancies: Full Term _____ Premature_____ C-section_____ Normal Delivery_____ Living_____

Twins/Multiples_____ Abortions_____ Miscarriages_____ Tubal Pregnancies_____

Past Pregnancies:

Preg #	Sex	Date	GA weeks	Wt	Labor Hrs	Type of delivery	Place of Delivery	Complications/Issues with pregnancy

Medical History

Please check all that apply to you and provide any additional comments.

- ☐ Diabetes: _____
- ☐ Hypertension: _____
- ☐ Heart Disease: _____
- ☐ Autoimmune disorder: _____
- ☐ Kidney disease/UTI: _____
- ☐ Neurologic/epilepsy: _____
- ☐ Psychiatric: _____
- ☐ Depression/postpartum depression: _____
- ☐ Hepatitis/Liver disease: _____
- ☐ Varicosities/phlebitis: _____
- ☐ Thyroid dysfunction: _____
- ☐ Trauma/violence: _____
- ☐ History of Blood Transfusion: _____
- ☐ Tobacco, Alcohol, or Substance Use

	Packs/Amount per day	Pre-Preg.	Preg.	# of years used
○ Tobacco				
○ Alcohol				
○ Illicit drugs				

- ☐ D (Rh) sensitized: _____
- ☐ Pulmonary (TB, Asthma): _____
- ☐ Seasonal allergies: _____
- ☐ Drug/latex allergies/reactions: _____
- ☐ Breast: _____
- ☐ GYN surgery: _____
- ☐ Operations/Hospitalizations: _____
- ☐ Anesthetic complications: _____
- ☐ History of abnormal PAP: _____
- ☐ Uterine anomaly: _____
- ☐ Infertility: _____
- ☐ Infertility Treatment: _____
- ☐ Have you had Chicken Pox? _____ Chicken Pox Vaccine? _____

Relevant Family History

Please list any conditions experienced by your family members and Indicate their relationship.

Relationship	Condition
1.	
2.	
3.	

Please answer the following questions.

Have you lived with someone with TB or been exposed to TB? ☐ Yes ☐ No

_____

Do you or your partner have a history of genital herpes? ☐ Yes ☐ No

_____

Experienced a rash/viral illness since last menstruation? ☐ Yes ☐ No

_____

Do you have Hepatitis B or C?

☐ Yes ☐ No

_____

Do you have a history of: ☐ STI ☐ Gonorrhea

☐ Chlamydia ☐ HPV ☐ HIV ☐ Syphilis

Allergies

Please list any medication or food allergies

☐ No allergies **Latex allergy:** ☐ Yes ☐ No

	Allergy	Reaction
1.		
2.		
3.		
4.		
5.		

Medications

List all medications you are currently taking or have taken since your last menstrual period, and the dosage. ☐ None

	Medication	Dosage	Start/Stop Date
1.			
2.			
3.			
4.			
5.			

*Note: If you have more than five medications, please fill out the medication form.

Symptoms since Last menstrual period

_____

PHARMACY _____

PHONE# _____

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Genetic Screening/Teratology Counseling

Please check all that apply and indicate if it applies to patient, baby's father, or parent's of patient or father.

	Relative
☐ Will be 36 years of age or older at estimated delivery date	
☐ Thalassemia (Italian, Greek, Mediterranean, or Asian Background)	_____
☐ Neural tube defects (meningomyelocele, spina bifida or anencephaly)	_____
☐ Congenital heart defects	_____
☐ Down Syndrome	_____
☐ Tay-sachs (Ashkenazi Jewish, Cajun, French Canadian)	_____
☐ Canavan disease (Ashkenazi Jewish)	_____
☐ Familial dysautonomia (Ashkenazi Jewish)	_____
☐ Sickle cell disease or trait (African)	_____
☐ Hemophilia or other blood disorders	_____
☐ Muscular dystrophy	_____
☐ Cystic fibrosis	_____
☐ Huntington's chorea	_____
☐ Mental retardation/autism	_____
☐ Other inherited genetic or chromosomal disorder	_____
☐ Maternal metabolic disorder (Type II Diabetes, PKU)	_____
☐ Patient or baby's father had a child with birth defects not listed above	_____
☐ Recurrent pregnancy loss or stillbirth	_____
☐ Any Other: _____	_____

Social History

Primary Language: _____ Education: _____ Baby's Father's Name: _____
Language at Home: _____ Home Hazards: _____ Phone: _____
Birthplace: _____ Support person: _____
Mother's Ethnicity: _____ Religion: _____ Phone: _____
Father's Ethnicity: _____

Occupation _____ Employer _____ Full Time/Part Time? _____

Pediatrician: _____
Prenatal Classes? ☐ Yes ☐ No Feeding: ☐ Breast ☐ Bottle ☐ Both
Agree to Blood Transfusion? ☐ Yes ☐ No Desire Sterilization? ☐ Yes ☐ No
Enrolled in WIC prenatal care program? ☐ Yes ☐ No

Are you exposed to smoking? ☐ Yes ☐ No Do you drink caffeine? ☐ Yes ☐ No ☐ Former

Do you exercise frequently? ☐ Yes ☐ No Are you a member of a Health Club? ☐ Yes ☐ No
Type of exercise: _____ Hobbies: _____ Diet History: _____

Possess Firearms? ☐ Yes ☐ No Home Smoke detectors? ☐ Yes ☐ No
Use seatbelts? ☐ Yes ☐ No Carbon Monoxide detector? ☐ Yes ☐ No
Do you have cats? ☐ Yes ☐ No Radon exposure in home? ☐ Yes ☐ No

_____

_____

Signature: _____ **Date:** _____

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Human Papillomavirus Testing

Human Papillomavirus, or HPV, is a sexually transmissible virus. There are over 100 different types of HPV – some types are known to cause common warts and other types are known to cause cervical cancer. The types of HPV that cause warts don't generally develop into anything severe; whereas, the HPV's that cause cervical cancer can develop into potentially serious health issues. The Pap Smear screens for the thirteen (13) types of high-risk HPV that are known to cause cervical problems. This screen is done at the laboratory once they have received the pap specimen, it is not performed here.

Unfortunately, not all insurance companies cover the HPV screening test.

I understand I will be completely responsible for the amount of this test if my insurance plan should not cover it.

Date: _____

Patient Signature: _____

Witness Signature: _____
Doctor's assistant

I decline testing _____

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Cystic Fibrosis Screening

Cystic Fibrosis is a disease that is genetically based and therefore can be passed from generation to generation. It greatly reduces the quality and length of the lives of its sufferers and although manageable, it is not curable. If you or the father of your baby have Caucasian heritage, it has been recommended to us to offer you a screening blood test to see if you may carry one of the gene mutations that can cause Cystic Fibrosis (CF). Overall, the chance of someone with Caucasian heritage for being a carrier for a CF gene is one in twenty-five, or 4 %.

Carrier frequency of CF

Ethnicity	Carrier Frequency
N. European Caucasian	**1/25**[1]
S. European Caucasian	**1/25**[1]
Ashkenazi Jewish	**1/29**[1]
Hispanic American	**1/46**[3]
African-American	**1/65**[3]
Asian	**1/90**[1]

Table 1 – Cystic Fibrosis Carrier Detection Rate and Carrier Risk

Ethnicity	Carrier detection Rate for CF mutations analyzed	CF carrier risk prior to testing	CF carrier risk after a negative result for mutations
Ashkenazi Jewish	97%[3]	1/29[3]	1/934[3]
Caucasian (Northern European)	90%[3]	1/25[3]	1/241[3]
Caucasian (Southern European)	70%[3]	1/25[3]	1/81[3]
Caucasian (Mixed European Ethnicity)	80%[4]	1/25[1]	1/140[4]
Hispanic American	57%[4]	1/46[4]	1/105[4]
African American	69%[4]	1/65[4]	1/207[4]
Asian	30%[3]	1/90[3]	1/128[3]
Other	_____	_____	Insufficient data

A negative test greatly reduces but doesn't totally eliminate the chances of your baby having CF. If you test positive for being a carrier, the father of the child then must be tested. If both parents are CF gene carriers, the chance is one in four of having a baby with CF. If the father is not a carrier and the mother is, or vice versa, the risk for the baby having CF is 1%. When a couple tests positive for CF mutation, we can do further testing to see if the baby has CF before it is born. You will be referred to a genetic counselor to explore your options.
Most insurance carriers will pay for this testing. It is, as many of the tests we offer, optional and you may decline testing if you desire. Any couple desiring this test may have it performed. If you don't know if you should have it done, please ask your provider for advice.

I desire testing for CF gene mutations _____

I decline testing. I understand this is a blood test and poses no risk to my pregnancy.

_____

Date _____

Consent for prenatal testing

Testing is available to all pregnant patients to identify those who are at an increased risk for defects involving the nervous system of the developing baby that create an opening to the outside of the baby, and Down Syndrome and other conditions resulting from having extra chromosomes. Although no test or combination of tests guarantee a healthy baby free of defects, screening blood and ultrasound tests are very sensitive for these problems and can be combined with special ultrasound examinations to find the majority of affected fetuses. "False positive results" – where the patient is identified as being at an increased risk but fortunately do not have a baby affected by the disorder tested for, do occur but infrequently enough so that the tests are still of value.

Integrated Serum Screening:

This is a blood test that measures protein levels in the Mother's blood. The first measurement is drawn at 10-13 weeks, and the second at 15-21 weeks. It detects 88% of Down syndrome babies, 90% of Trisomy 18 (where there is an extra chromosome 18), and 80% of open spinal defects. The false positive rate for Down Syndrome is 6%, for Trisomy 18 is only 1/10th of a percent, and for Open Spinal Defect is 1-3%.

First Trimester Screening with Nuchal Fold Translucency:

The Mother's blood is tested at 10-13 weeks and an ultrasound is performed to measure the space between the skin at the back of the fetus's neck and the underlying tissues. This ultrasound is performed at centers specially qualified to perform this ultrasound, and, if you desire this test, a referral will be made to a Specialist at whose office the test can be performed. It detects 86% of Down Syndrome with only a 5% false positive rate, and 75% of Trisomy 18 with only a ½% false positive rate. It does not detect Open Spinal defects, but is commonly paired with an alpha-fetoprotein blood test at 15-23 weeks. **The main advantage lies in the earlier possible detection of chromosome disorders.**

AFP Tetra Screening:

Some patients come to us too late to offer the above tests. These patients can have blood tests performed at 15-21 weeks to screen for the same problems. The detection rate for Down Syndrome is lower, around 75-80% with a 5% false positive rate, Trisomy 18 is detected in 73% of people who have a fetus with this disorder with a false positive rate of ½% and Open Spinal defect detection rate the same as the above tests.

Screening ultrasound for anatomy is performed on all patients at 18-19 weeks regardless of whether optional blood testing is performed.

I have read the above and decline the optional blood tests _____

I would like to have the following test (choose one):

First Trimester Screen with Nuchal Fold Translucency _____

Integrated Screen _____

AFP Tetra Screen _____

Patient's signature _____