Welcome to Trinity Women's Health! We hope that this informational letter is helpful to you.

Our Practice:

- Hours: Monday – Thursday 8:00 – 5:00 and Friday 8:00 – 12:00
- Office (951) 894-4436 Fax: (951) 677-8080.
- Website: www.trinitywomenshealth.com
- Currently staffed by two physicians: Dr. Joan Hazel Calinisan, and Dr. Nerissa Safie.

Our physicians have privileges and deliver at the following hospitals:

Loma Linda Medical Center
28062 Baxter Road
Murrieta, CA 92562
(951) 290-4000

Rancho Springs Medical Center
25500 Medical Center Drive
Murrieta, CA 92563
(951) 696-6000

Please be advised:

- It is the patient's responsibility to contact their insurance to find out hospital coverage and your share of cost. Inquires should be directed to your healthcare carrier. Your insurance carrier can be reached by calling the member services number listed on your card.
- If your insurance carrier or coverage changes, please notify our office immediately.
- If you are a surrogate, you **MUST** inform your provider at your initial visit. Please be advised that not all insurances cover services provided to a surrogate. Any charges not covered by your insurance will be patient responsibility.

Signature:_____ Date: _____

Cancer Risk Assessment Questionnaire

_____ _____/_____/_____ _____/_____/_____

Patient Name Date of Birth Date Completed

This is a screening tool for the common features of hereditary cancer. Our service will allow us to give you the most technologically advanced screening possible to increase the chances of cancer detection and early intervention to optimize your health.

Circle Y for those that apply to YOU and/or YOUR FAMILY (consider all relatives on both mother's and father's side). YOU AND THE FOLLOWING CLOSE BLOOD RELATIVES SHOULD BE CONSIDERED. ***Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins (IF MULTIPLE), Great Grandparents (IF MULTIPLE), Great Aunt/Uncle (IF MULTIPLE)***

TYPES OF CANCER			RELATIONSHIP TO FAMILY MEMBER w/ CANCER and AGE at DIAGNOSIS		
			SELF/ SIBLING	MOTHER or Relatives on MOTHERS's side	FATHER or Relatives on FATHER's side
		EXAMPLE:	Me 35 Sister 40	Aunt 35	Grandmother 75
Y	N	Do you have a relative with Breast cancer **before** age 50?			
Y	N	Two breast cancers; one must be **50 or younger** (must be on same side of family to qualify) Three or more breast cancers; they can be at **any age** (must be on same side of family to qualify)			
Y	N	Do you have a relative with Ovarian cancer **at any age**?			
Y	N	Do you have a relative with Male breast cancer **at any age**?			
Y	N	Ashkenazi Jewish ancestry ***with*** breast or ovarian cancer in a ***family member*** **at any age**?			
Y	N	Do you have a relative with Colon Cancer **before** Age 50?			
Y	N	Do you have a relative with Endometrial Cancer **before** Age 50?			
Y	N	Do you have **3 relatives** with Colon cancer or endometrial cancer **at any age** on the same side of the family??			
Y	N	Do you have **Ten or more** lifetime colon polyps?			
Y	N	Any other cancers?			

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No ☐ Do Not Know

Patient signature: _____ Date: _____

For Office Use Only:

Patient offered testing ☐ Accepted ☐ Declined Reason for decline: _____

☐ Does Not Meet Criteria ☐ Sample Collected

Office Signature_____

TRINITY WOMEN'S HEALTH
NEW PATIENT INTAKE FORM

PATIENT INFORMATION

PATIENT NAME:_____ DOB: _____
LAST FIRST

PATIENT ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____ HOME #: _____

CELL #:_____ SSN# (NEED FOR BILLING):_____EMAIL:_____

RESPONSIBLE PARTY (IF MINOR):_____ RELATIONSHIP:_____

EMPLOYER: _____ CONTACT PERSON:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____ WORK #: _____

EMERGENCY CONTACT: _____ RELATIONSHIP:_____ PHONE#:_____

PRIMARY CARE DOCTOR: _____ HOSPITAL: _____

SPOUSE INFORMATION

SPOUSE'S NAME:_____ DOB: _____
LAST FIRST

SPOUSE'S SSN#:_____ CELL #:_____

INSURANCE INFORMATION

SUBSCRIBER NAME:_____ SUBSCRIBER DOB:_____
LAST FIRST

NAME OF PRIMARY INSURANCE:_____

SUBSCRIBER ID#:_____ SUBSCRIBER GROUP#:_____

NAME OF SECONDARY INSURANCE:_____

SUBSCRIBER ID#:_____ SUBSCRIBER GROUP#:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to the physicians of Trinity Women's Health (Drs Calinisan, and/or Safie) for services rendered by them in person or under their supervision. I understand that I am **financially responsible for any balance not covered by my insurance.**

Patient Name /guardian (please print)_____

Patient Signature_____ **Date:**_____

PATIENT INTAKE

PATIENT NAME:_____ DOB: _____
LAST FIRST

LAST MENSTRUAL CYCLE: _____

MARITAL STATUS: SINGLE/ MARRIED/ DIVORCED/ WIDOWED **HEIGHT: _____ WT:_____**

PAST MEDICAL & FAMILY HISTORY	**PLEASE MARK (X) IF YOU (SELF) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS**					
	SELF	FAM	OTHER/COMMENTS		SELF	FAM
RHEUMATIC HEART				ANEMIA		
HIGH BLOOD PRESSURE				BLOOD CLOTS (DVT)		
HIGH CHOLESTEROL				DIABETES		
CONGESTIVE HEART				THYROID DISEASE		
ASTHMA				EPILEPSY		
COPD				ALZHEIMER'S		
HEPATITIS				OSTEOPOROSIS		
GERD / OTHER				ANXIETY/DEPRESSION		

OBSTETRIC HISTORY	#TOTAL PREGNANCY		# TERM DELIVERY		#PRETERM DELIVERY		#ABORTION/ MISCARRIAGE		#LIVING CHILDREN	
DATE OF BIRTH	SEX		DELIVERY TYPE				REMARKS			

GYNECOLOGIC HISTORY	AGE AT FIRST PERIOD		AGE AT LAST PERIOD	
	PERIOD INTERVAL (1ST DAY TO 1ST DAY)		DURATION OF BLEEDING	
PAP TEST	DATE OF LAST TEST □ NORMAL □ ABNORMAL		MAMMOGRAM	DATE OF LAST TEST □ NORMAL □ABNORMAL
SEXUALLY TRANSMITTED DISEASES	□ HERPES □ SYPHILIS □ CHLAMYDIA □ GONORRHEA □ HIV/AIDS			
CONTRACEPTIVE HISTORY	CURRENT CONTRACEPTIVE			
SOCIAL HISTORY	SMOKING CIG/ DAY		# YEARS	ALCOHOL DRINKS/ WK
	DO YOU FEEL SAFE AT HOME □ YES □ NO		HISTORY OF ABUSE □ YES □ NO	

MEDICATIONS	**DOSE**	**ALLERGIES TO MEDICATION**	**REACTION**

SURGERY	**DATE**	**SURGERY**	**DATE**

REVIEW OF SYSTEMS - PLEASE MARK (X) ALL THAT APPLY

	YES	NO		YES	NO
GENERAL			**CARDIOVASCULAR**		
WEAKNESS			CHEST PAIN DURING EXERTION		
UNEXPLAINED WEIGHT LOSS			DECREASED EXERCISE TOLERANCE		
PERSISTENT FEVER			SWELLING OF HANDS OR LEGS		
SKIN			PALPITATIONS		
JAUNDICE			**RESPIRATORY**		
HIVES, ECZEMA OR RASH			CHRONIC COUGH		
FREQUENT BOILS OR INFECTION			ASTHMA OR WHEEZING		
ABNORMAL PIGMENTATION			BLOOD IN SPUTUM		
EASY TO BRUISE			**GASTROINTESTINAL**		
NEUROLOGIC			HEARTBURN OR INDIGESTION		
CONVULSIONS			NAUSEA OR VOMITING		
MEMORY LOSS			DIARRHEA		
HEADACHES			CONSTIPATION		
POOR COORDINATION			BLOOD IN STOOL		
EYES/EARS/NOSE/THROAT			ABDOMINAL PAIN OR CRAMPS		
DOUBLE VISION OR BLURRY VISION			EARLY SATIETY		
FLOATERS			LOSS OF APPETITE		
LOSS OF HEARING			**REPRODUCTIVE**		
RINGING IN EARS			IRREGULAR MENSTRUATION		
LOSS OF SMELL			LOSS OF MENSTRUATION		
BREAST			HEAVY BLEEDING		
LUMPS			PAIN WITH INTERCOURSE		
DISCHARGE			LOSS OF LIBIDO		
TENDERNESS			SPOTTING		
ENDOCRINE			**UROLOGIC**		
EXCESS THIRST			FREQUENT OR PAINFUL URINATION		
EXCESS URINATION			BLOOD IN URINE		
HEAT OR COLD INTOLERANCE			LOSS OF URINE CONTROL		
PSYCHOLOGIC			MUSCULOSKELETAL		
FEELINGS OF GUILT			MUSCLE CRAMPS		
THOUGHTS OF HURTING SELF			PAINFUL JOINTS		
THOUGHTS OF HURTING OTHERS			SWOLLEN JOINTS		

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

TRINITY WOMEN'S HEALTH OFFICE POLICIES

Your appointment will be rescheduled if you arrive more than 15 minutes late to your scheduled appointment time.

New patients must be here 30 minutes prior to appointment.

Any voicemails left will be checked throughout the same business day.

There is a 72-hour turn around for all **prescription refills**. If you need a prescription refill, have your pharmacist fax a refill request to our fax number **(951) 677-8080** and we will take care of it accordingly.

There will be a $30.00 ***CASH*** fee on all personal paperwork completed by our physicians (DMV forms, EDD forms, FMLA forms, etc.)

There is a **$50.00 fee for any missed appointments not cancelled 24 hours in advance**. That includes same day cancellations. Please contact us as soon as possible to cancel your appointment.

PHARMACY INFORMATION

To facilitate your prescription orders and refills, we encourage you to use our preferred pharmacy, Rancho Springs Outpatient Pharmacy, conveniently located downstairs in Suite #110. Most insurance plans are accepted. The pharmacy can also transfer out your prescription to your preferred pharmacy**. Free delivery and free mail order options are available.**

Rancho Springs Outpatient Pharmacy
25485 Medical Center Dr., Ste #110
Murrieta, CA 92562

-

Phone 951-698-4505 Fax 951-698-4506
Hours M-F 8:30am- 5:00pm

☐ By checking this box I acknowledge that I do not wish to use the preferred pharmacy and will choose my own pharmacy.

Alternate Choice #1:

Name of Pharmacy | Address | Phone Number

Alternate Choice #2:

Name of Pharmacy | Address | Phone Number

PATIENT CONSENTS

PLEASE INITIAL SPACE BELOW

- I authorize the release of any Medical Information to process claims. _____
- I authorize the release of payment for Medical Benefits to Trinity Women's Health. _____
- I consent to and authorize the performance of all treatments, surgery, and medical health services by the staff of Trinity Women's Health which they deem advisable. I certify that to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. _____
- I agree to pay legal interest, collection expense, and attorney's fees incurred to collect any amount that I may owe. I also authorize Trinity Women's Health to release information requested by my insurance company and/or its representatives. _____
- I authorize Trinity Women's Health to photograph me and/or my medical condition for **medical records and surgical purposes ONL**Y. _____
- I acknowledge the HIPAA (privacy practices notice) is available to print online or available on request. _____
- **I acknowledge that my insurance may be billed for any records reviewed _____.**
- **I acknowledge that any telephone calls to Trinity Women's Healthcare providers may be subject to telemedicine charge through my insurance**._____.
- I give permission to this office to release medical and billing information on my behalf, to the following person(s).

Name: _____ Relationship: _____

Phone #: _____ Date of Birth: _____

ZERO Tolerance policy: Trinity Women's Health adheres to a zero-tolerance policy and has the right to terminate a relationship with any patient who's abusive (including yelling or threatening physicians, staff, or others), who fails to follow directions or who does not pay for/make arrangements to pay for services. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice. Initial_____.

-PATIENT NAME/GUARDIAN (PLEASE PRINT): _____

-PATIENT SIGNATURE: _____ **DATE:** _____

PRIVATE POLICY STATEMENT

PURPOSE: The following policy is adopted to ensure that Trinity Women's Health complies fully with all federal and state privacy protection laws including HIPAA and California law. Violations of these polices will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution

NOTICE OF PRIVACY PRACTICE: It is the policy of Trinity Women's Health that a notice of privacy practices must be published, that a copy of this notice provided to patients at first encounter, and that all uses and disclosures of health information be done in accord with this policy. It is also the policy of the medical practice to post the most current privacy practices in the waiting room and to have copies available for distribution at our reception area.

ASSIGNING PRIVACY AND SECURITY RESPONSIBILITIES: It is the policy of Trinity Women's Health that specific individuals under our employment are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Act's requirements. It is further the policy that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum, it is the policy of the medical practice that there will be one individual designated as the Privacy Official.

DECEASED INDIVIDUALS: It is the policy of Trinity Women's Health to extend privacy protections to information regarding deceased individuals

MINIMUM NECESSARY USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: It is the policy of Trinity Women's Health that for all routine and recurring uses and disclosures of protected health information except for disclosures made for treatment purposes, or as authorized by patient or as required by law for HIPAA compliance, that such uses and disclosures be limited to the minimum amount of information needed to accomplish the purpose or use of disclosure. It is further policy that non-routine uses and disclosures be handled pursuant to established criteria. All requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

MATERIAL CHANGE: It is the policy of Trinity Women's Health that the term "material change" refers to any change in our HIPAA compliance activities

SANCTIONS: It is the policy of Trinity Women's Health that sanctions will be in effect for any member of our staff who intentionally or unintentionally violates any of these policies or procedures related to fulfillment of these policies. Such sanctions will be kept as a permanent record on the individual's personnel file.

RETENTION OF RECORDS: It is the policy or Trinity Women's Health that the HIPAA Privacy Act records retention requirement of six years will be adhered to. All records designated by HIPAA will be maintained in a manner that allows for access within a reasonable amount of time. This records retention time may be extended at this medical practice's discretion to meet with other governmental regulations or requirements imposed by professional liability carriers.

COOPERATION WITH PRIVACY OVERSIGHT AUTHORITIES: It is the policy of Trinity Women's Health that oversight agencies such as the Office of Civil right of the Department of Health and Human Services be given full cooperation in their efforts to ensure protection of health information within the organization. All personnel must fully cooperate with privacy compliance reviews and investigations.

Please read the following financial policies of this office:

NOTE: YOU WILL RECEIVE A SEPARATE BILL FROM THE LABORATORY FOR ANY LABORATORY SERVICES ORDERED (I.E., PAP SMEAR, URINALYSIS, BIOPSIES, CULTURES, BLOOD WORK, ETC.). THESE CHARGES ARE NOT INCLUDED IN OUR BILL. IF YOUR INSURANCE COMPANY IS CONTRACTED WITH A SPECIFIC LABORATORY FOR PAP SMEARS, BLOOD WORK, ETC., YOU MUST NOTIFY US AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR INFORMING THE NURSE BEFORE THE END OF YOUR APPOINTMENT.

PRIVATE INSURANCE: As a courtesy, we will bill your insurance company. We will, however, collect all percentages and/or deductibles at the time of your visit. If your insurance company requires their insurance claim form be utilized, rather than the universal HCFA 1500, it will be the patient's responsibility for providing the form prior to their office visit. If such a form is unavailable, then we will collect all charges and then you will be responsible for billing your insurance company.

SURGERY: The office will bill for all surgery charges. Please assign authorization of payment directly to the physician. Prior to your surgery, please make arrangements for payment of any deductibles and/or co-payments. If you are not covered by insurance, payment in full will be expected on the day of your pre-operative appointment. Please be aware that there may be an assistant fee, anesthesiologist fee, laboratory fee, and radiologist fee, etc.

PREFERRED PROVIDER ORGANIZATIONS (PPO or HMO): If you are covered by an insurance company that we are contracted with, please present your membership card at the front desk. We will bill your insurance company. Any co-payment will be expected at the time of your visit. Please be aware that a prior authorization may be necessary for your visit and must be obtained prior to your visit. Prior authorization is a requirement of many HMO's and their procedures and policies MUST be followed.

SECONDARY INSURANCE: Our office will bill your secondary insurance as long as the secondary allowable is greater than the primary allowable. Our office will bill your secondary insurance as a courtesy to you one time. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. At your request, we will assist you with any information you may need to bill your secondary again.

CASH: If you do not have insurance, you will be expected to make payment at the time of service. Please stop at the front desk after each Gynecological or Obstetrical visit.

ALL OBSTETRICAL PATIENTS: An account will be established on your first visit. If you have pregnancy health insurance coverage it will not be billed until you have delivered. However, any additional fees not included in your obstetrical care, such as ultrasounds, are due and payable at the time of service. You will also be responsible for all co-payments and deductibles to be paid in full by your 24th week of pregnancy. Payment arrangements should be arranged on your first visit. If you are a member of a PPO or HMO, your co-payments will be expected at each visit, if applicable. An obstetrical contract will be generated and mailed to you by our biller Susan Ford (951) 694-6102
If you have any questions, please feel free to stop at the front desk. We are here to help you in any way possible.

I have read the above information and understand my financial obligation to Trinity Women's Health

_____ _____

Patient Signature Date

PATIENT FINANCIAL RESPONSIBILITY CONSENT FORM

Welcome to Trinity Women's Health. Please read carefully this important information regarding your responsibility for payment for your care and services.

The providers at Trinity Women's Health are participating providers with most insurance companies. However, our list of accepted insurances is subject to change at any time and not all plans under all companies are accepted. In order to avoid unexpected changes, please confirm that your particular health plan is accepted by Trinity Women's Health. You should reach out to your carrier when you initiate care to familiarize yourself with the limits of your policy and what will and will not provide coverage for. We do our best to guide patients through this process, but ultimately it is impossible for us to keep abreast of the requirements in the thousands of insurance products on the market. It is an individual patient responsibility to understand the provisions, limits, and requirements of their individual benefit plan(s) and advise us accordingly.

Please be aware that, except as contractually agreed otherwise by Trinity Women's Health, patients are ultimately responsible for insuring payment for all medical services provided. If a carrier denies payment for services because a plan requirement was not met, services were considered "non covered", the plan benefits were exceeded, care is considered medically unnecessary, or treatment is considered experimental, among other reasons, patients will be held accountable for those charges. Although Trinity Women's Health will submit a claim to insurance for our patients, if your insurance requires you to pay a co-payment and or deductible, you will be required to pay that portion at time of service

LABWORK: Please be aware that Trinity Women's Health has no role in or control over billing issues related to clinical laboratory fees. If you have any questions about bills received for laboratory charges or insurance coverage available to you, please contact the clinical laboratory in question and / or your insurance carrier. We regret that our billing staff cannot be of assistance to you in mitigating laboratory charge issues.

OTHER FEES NOT COVERED BY INSURANCE:

Appointment Cancellations:

When you make an appointment, we reserve time specifically for you. Unfortunately, when a patient does not show for their schedule appointment, another patient loses an opportunity to be seen. Therefore, if you need to cancel or re-schedule, you are asked to notify us as soon as possible, by no later than 24 hours in advance. Appointments cancelled without 24 hours notice will be assessed a cancellation fee of $50.00. Habitually cancelling your appointments may cause us to ask you to find another physician for your healthcare needs.

Patient Signature: _____ Date: _____

Print Name: _____

Screening SMA and Cystic Fibrosis

Everyone has a risk to have a baby with problems. There are a few common disorders that can occur even without a family history and can be tested for today. You can have one simple blood test before the baby is born to determine if you carry the gene (DNA change) that causes the disorders shown below.

What is a carrier?
A carrier is a person who has a gene that increases the risk to have children with a genetic disease. People do not know if they are carriers until they have a blood test or an affected child. Some disorders occur only if both parents are carriers and other disorders only occur when the mother is a carrier.

What is carrier screening?
Carrier screening involves a blood test from one or both parents to determine if they carry a specific gene that increases the risk that their baby is affected. If you turn out to be at risk, prenatal testing such as amniocentesis or choronic villus sampling (CVS) is available to determine if your unborn baby is affected. All testing is optional and you can choose which disorder(s) to be tested. **CHECK WITH YOUR INSURANCE TO SEE WHAT YOU WILL BE RESPOSIBLE FOR.**

Disease	Cystic Fibrosis (CF)	Fragile X Syndrome	Spinal Muscular Atrophy (SMA)
Symptoms of Disease	*Most common inherited disease in North America.* A chronic disorder that primarily involves the respiratory, digestive and reproductive systems. Symptoms include pneumonia, diarrhea, poor growth and infertility. Some people are only mildly affected, but individuals with severe disease may die in childhood. With treatments today, people with CF can live into their 20's and 30's. CF does not affect intelligence.	*The most common inherited cause of mental retardation.* Fragile X syndrome is a disorder that causes mental retardation, autism, and hyperactivity. It affects primarily boys. Women who are carriers are at risk to have a child with mental retardation.	*Most common cause of inherited infant death.* SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling their head or neck, and crawling or walking. The most common form of SMA affects infant in the first months of life and can cause death between 2-4 years of age. Less commonly the disease starts later and people can survive into adulthood. SMA does not affect intelligence. There is no cure or treatment.
Inheritance	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with cystic fibrosis.	If a mother is a carrier, there is up to a 50% chance to have a child affected with fragile X syndrome	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with SMA
Population Incidence	1 in 2500 Caucasians 1 in 8400 Hispanics 1 in 16,900 African Americans 1 in 32,000 Asians Americans	Approximately 1 in 4000 males Occurs in all ethnic backgrounds	1 in 10,000 Occurs in all ethnic backgrounds.
Are you interested in testing? (please circle one)	YES NO	YES NO	YES NO

_____ _____

Patient Signature Date

OBSTETRIC QUESTIONNAIRE

DATE _____

NAME_____ ETHNICITY: American Indian or Alaska Native White Asian
(circle all that applies) Black or African American Native Hawaiian or Pacific Islander

Date of Birth_____ AGE _____ Hospital of Delivery _____

Please list all pregnancies, including miscarriages, abortions and ectopic pregnancies. Please include full birthdate.

TOTAL PREGNANCY (including this pregnancy)	FULL TERM	PREMATURE	MISCARRIAGE	MULTIPLE BIRTHS	ECTOPIC	LIVING

PAST PREGNANCIES

Type: vaginal, c-section, forceps, or vacuum **Anesthesia:** epidural, local, general, spinal

Complications: EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression If preterm labor, were medications used?___

Birthdate	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Place of Delivery	Complications

Reproductive History: Menstrual Cycle

Age at first period? _____

First day of last menstrual period _____

How often do you get your menstrual cycle? Every _____days, lasting _____ days.

Are your cycles? REGULAR IRREGULAR

Was this pregnancy conceived on birth control pills? YES NO

Last pap smear _____

Any abnormal Pap smears? YES NO

Height _____ Weight _____

Medications (include Over The Counter medications)	**Dose**	**Allergies to Medications**	**Reaction**
Surgery	**Date**		

Social History

Tobacco Use: Never Current _____# of Cigarettes per day Former, Quit at age_____

Any alcohol use: YES NO *If yes, the average number of drinks per week _____

Do you use street drugs? YES NO *If yes, the type used and last use _____

Any history of violence or abuse in your current household or in your past? YES NO

Do you have any cultural or religious considerations that need special attention? YES NO

Medical History: Do you know or have you ever had: (circle all that applies)

○ Asthma ○ Autoimmune Disorder _____ ○ Bleeding Disorder ○ Blood Transfusion ○ Bone/ Joint Disease ○ Cancer (type)_____ ○ Chicken pox ○ Chicken pox vaccination ○ Chlamydia ○ Deep Vein Thrombosis ○ Infertility ○ Thalassemia (Italian, Greek, Mediterranean or Asian) ○ Neural Tube Defect (Meningomyelocele, Spinabifida, Oranencephaly)	○ Depression ○ Diabetes Type I ○ Diabetes Type II ○ Elevated Cholesterol ○ Endometriosis ○ Fibroids ○ GERD/ Reflux ○ G.I. Illness ○ Gestational Diabetes ○ Heart Disease ○ Hepatitis A ○ Hepatitis B ○ Hepatitis C ○ Liver Disease ○ Infertility ○ Down Syndrome ○ Sickle Cell Disease ○ Muscular Dystrophy ○ Hemophilia ○ Kidney Disease/ UTI	○ Other Inherited Genetic or Chromosomal Disorder ○ Maternal Metabolic Disorder (Insulin Dependent Diabetes) ○ HPV/ Genital Warts ○ High Blood Pressure ○ Thyroid Dysfunction ○ Seizures ○ Huntington's Chorea ○ Mental Retardation/ Autism ○ Tuberculosis ○ Tay Sachs Disease ○ Anesthetic Complications ○ Trauma ○ Cystic Fibrosis	○ Breast ○ Gyn Surgery _____ ○ Uterine Anomaly ○ Patient or Baby's Father had a child with birth defects not listed above ○ Recurrent Pregnancy loss or still birth ○ Congenital Heart Defect ○ Other _____
STD's: Chlamydia Gonorrhea HIV Herpes Syphilis None (circle all that applies)			

How old will you be by your due date? _____

Is this pregnancy the result of infertility treatments? YES NO If so, what kind _____

Are you interested in screening for birth defects and chromosomal abnormalities? YES NO
(ultrasound and blood tests offered to all pregnant women)

Do you want a blood test to determine if you carry the gene for:

- Cystic Fibrosis (Caucasian and Jewish patients at highest risk) YES NO
- Sickle Cell Disease (African-American and Hispanic patients at highest risk) YES NO
- Tay Sachs Disease (Jewish patients at highest Risk) YES NO

All above testing is optional and you can choose which disorder(s) to be tested. **CHECK WITH YOUR INSURANCE TO SEE WHAT YOU WILL BE RESPONSIBLE FOR.**

Patient's Signature:_____ Date: _____