Patient Addressograph

DATE: _____

NAME: _____
LAST FIRST MIDDLE

ID #: _____ HOSPITAL OF DELIVERY: _____

NEWBORN CARE PROVIDER: _____ REFERRED BY: _____

PRIMARY PROVIDER/GROUP: _____

FINAL EDD: _____ ADDRESS: _____

BIRTH DATE: MONTH DAY YEAR AGE: RACE: MARITAL STATUS: S M W D SEP	ADDRESS:
OCCUPATION: EDUCATION: (LAST GRADE COMPLETED)	ZIP: PHONE: (1) (2)
LANGUAGE: ETHNICITY:	E-MAIL:
HUSBAND/DOMESTIC PARTNER: PHONE:	INSURANCE CARRIER/MEDICAID #:
FATHER OF BABY: PHONE:	POLICY #:
	EMERGENCY CONTACT: PHONE:

TOTAL PREG:	FULL TERM:	PREMATURE:	AB, INDUCED:	AB, SPONTANEOUS:	ECTOPICS:	MULTIPLE BIRTHS:	LIVING:

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENSES MONTHLY ☐ YES ☐ NO FREQUENCY: Q _____ DAYS MENARCHE: _____ (AGE ONSET)
☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION PRIOR MENSES: _____ DATE ON BCP AT CONCEPT ☐ YES ☐ NO hCG + ____/____/____
☐ FINAL: _____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
A. DRUG/LATEX ALLERGIES/ REACTIONS		
B. ALLERGIES (FOOD, SEASONAL, ENVIRONMENTAL)		
1. NEUROLOGIC/EPILEPSY		
2. THYROID DYSFUNCTION		
3. BREAST DISEASE		
4. PULMONARY (TB, ASTHMA)		
5. HEART DISEASE		
6. HYPERTENSION		
7. CANCER		
8. HEMATOLOGIC DISORDERS		
9. ANEMIA		
10. GASTROINTESTINAL DISORDERS		
11. HEPATITIS/LIVER DISEASE		
12. KIDNEY DISEASE/UTI		
13. VARICOSITIES/PHLEBITIS		
14. DIABETES (TYPE 1 OR TYPE 2)		
15. GESTATIONAL DIABETES		
16. AUTOIMMUNE DISORDERS		
17. DERMATOLOGIC DISORDERS		

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
18. OPERATIONS/HOSPITALIZATIONS (YEAR & REASON)		
19. GYN SURGERY		
20. ANESTHETIC COMPLICATIONS		
21. HISTORY OF BLOOD TRANSFUSIONS		
22. INFERTILITY		
23. ASSISTED REPRODUCTIVE TECHNOLOGY		
24. UTERINE ANOMALY/DES		
25. HISTORY OF ABNORMAL PAP		
26. HISTORY OF STI		
27. PSYCHIATRIC ILLNESS		
28. DEPRESSION/POSTPARTUM DEPRESSION		
29. TRAUMA/VIOLENCE		

		PREPREG	PREG	# YEARS USE
30. TOBACCO (AMT/DAY)				
31. ALCOHOL (AMT/WK)				
32. ILLICIT/RECREATIONAL DRUGS (USES/WK)				
33. RELEVANT FAMILY HISTORY				
34. OTHER				

COMMENTS: _____

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

GENETIC SCREENING*/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80			12. HUNTINGTON CHOREA		
2. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			13. MENTAL RETARDATION/AUTISM		
			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
5. TAY–SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)			16. BIRTH DEFECTS NOT LISTED ABOVE		
6. CANAVAN DISEASE (ASHKENAZI JEWISH)			17. RECURRENT PREGNANCY LOSS OR A STILLBIRTH		
7. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN AMERICAN)					
9. HEMOPHILIA OR OTHER BLOOD DISORDERS			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. MUSCULAR DYSTROPHY			19. ANY OTHER		
11. CYSTIC FIBROSIS					

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

INFECTION HISTORY	YES	NO	
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5. HISTORY OF STIs: GONORRHEA, CHLAMYDIA, HPV, SYPHILIS, PID (CIRCLE ALL THAT APPLY)
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			6. HIV INFECTION YES ☐ NO ☐
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			7. HISTORY OF HEPATITIS
4. PRIOR GBS-INFECTED CHILD			8. OTHER (SEE COMMENTS)

COMMENTS: _____

INTERVIEWER'S SIGNATURE: _____

IMMUNIZATIONS	YES (MONTH/YEAR) ____ / ____	NO	IF NO, POSTPARTUM VACCINE INDICATED?	IMMUNIZATIONS	YES (MONTH/YEAR) ____ / ____	NO	IF NO, POSTPARTUM VACCINE INDICATED?
TDAP or TD				HEPATITIS A (WHEN INDICATED)			
INFLUENZA†				HEPATITIS B (WHEN INDICATED)			
VARICELLA†				MENINGOCOCCAL (WHEN INDICATED)			
MMR†				PNEUMOCOCCAL (WHEN INDICATED)			

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the MMR and varicella vaccines postpartum if needed.

INITIAL PHYSICAL EXAMINATION

DATE: ____ / ____ / ____ WEIGHT: ____ HEIGHT: ____ BMI: ____ BP: ____

1. HEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS
2. TEETH	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE
3. SYMPTOMS SINCE LMP	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	____ WEEKS		☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS	
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL	
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO	____ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT	☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT	☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS (Number and explain abnormals): _____

EXAM BY: _____

Patrick Diesfeld, M.D.
Sally McNally, C.N.M.
Bethany Mesker, C.N.M.
Jacqueline Lagana, C.N.M.

Informed Consent/ Decline for Cystic Fibrosis Carrier Testing

1. The purpose of the test is to determine whether I am a carrier of one of the common CF mutations.
2. The decision to have CF carrier testing is completely mine.
3. The test does not detect all CF carriers.
4. If I am a carrier, testing my partner will help me learn more about the chance that our baby could have CF.
5. If one parent is a carrier and the other is not, it is still possible that the baby will have CF, but the chance is very small.
6. If both parents are carriers, prenatal testing can be done to find out whether or not the baby has inherited the CF gene.
7. The laboratory needs accurate information about my family history and ethnic background for the most accurate interpretation of the test results.
8. No other test will be performed and reported on my sample unless authorized by my doctor, and any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory.
9. The laboratory will disclose the test results ONLY to my doctor, or to his/ her agent, unless otherwise authorized by me or required by law.

Informed Consent/ Decline for Cystic Fibrosis Carrier Testing

I have read, or had read to me, the information in this brochure and I understand it. Before signing this form, I have had the opportunity to discuss CF testing further with my doctor, someone my doctor has designated, or to a genetic professional. I have all the information I want, and all my questions have been answered. I have decided that:

I DO NOT WANT CF CARRIER TESTING. _____

I WANT CF CARRIER TESTING. _____

Patient Signature_____

Date_____

Yes I Consent to Screening	I consent to participate in the California Prenatal Screening Program. I request that blood be drawn for Prenatal Screening. I agree that my specimen may be used for research by the Department of Public Health, or Department approved researchers, unless I mark the box below. ☐ I decline the use of my specimen for research. The Department will maintain confidentiality according to applicable laws and regulations. Signed_____Date_____

No I Decline Screening	I decline to participate in the California Prenatal Screening Program. I request that blood not be drawn for Prenatal Screening. Signed_____ Date_____

Patrick W. Diesfeld, M.D.
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THE USE OF DRUGS AND MARIJUANA IN PREGNANCY

The use of drugs during pregnancy is not only detrimental to the pregnancy but does pose increased risk for your baby. This includes the increased possibility of abnormalities in the baby, as well as the increased risk of problems with the baby getting enough oxygen. My physician and I have discussed the risks of drug use during pregnancy to my unborn child and myself. My questions have been answered. This office reserves the right to do drug testing on obstetrical patients at any time during the pregnancy because of these problems.

I have read and understand that drug screening may be done during the pregnancy at the discretion of the physician.

Signature_____ Date_____