DATE _____

NAME _____
LAST FIRST MIDDLE

ID# _____ HOSPITALOFDELIVERY _____

NEWBORN'SPHYSICIAN _____ REFERREDBY _____

FINALEDD _____ PRIMARYPROVIDER/GROUP _____

BIRTHDATE AGE RACE MARITALSTATUS
S M W D SEP

OCCUPATION EDUCATION
☐ HOMEMAKER (LASTGRADECOMPLETED)
☐ OUTSIDEWORK
☐ STUDENT TypeofWork

HUSBAND/FATHEROFBABY PHONE

ADDRESS

ZIP PHONE (H) (O)

INSURANCECARRIER/MEDICAID#

EMERGENCYCONTACT PHONE

TOTALPREG	FULLTERM	PREMATURE	AB.INDUCED	AB.SPONTANEOUS	MULTIPLEBIRTHS	ECTOPICS	LIVING

MENSTRUALHISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE(MONTHKNOWN) MENESMONTHLY ☐ YES ☐ NO FREQUENCY:Q _____ DAYS MENARCHE _____(AGEONSET)
☐ UNKNOWN ☐ NORMALAMOUNT/DURATION PRIORMENES _____ DATE ONBCPATCONCEPT. ☐ YES ☐ NO hCG+ _____ / _____ / _____
☐ FINAL _____

PASTPREGNANCIES(LASTSIX)

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

PASTMEDICALHISTORY

	ONeg +Pos	DETAILPOSITIVEREMARKS INCLUDEDATE&TREATMENT				ONeg +Pos	DETAILPOSITIVEREMARKS INCLUDEDATE&TREATMENT
1.DIABETES					16.D(Rh)SENSITIZED		
2.HYPERTENSION					17.PULMONARY(TB,ASTHMA)		
3.HEARTDISEASE					18.ALLERGIES(DRUGS)		
4.AUTOIMMUNEDISORDER					19.BREAST		
5.KIDNEYDISEASE/UTI					20.GYNSURGERY		
6.NEUROLOGIC/EPILEPSY							
7.PSYCHIATRIC							
8.HEPATITIS/LIVERDISEASE					21.OPERATION/HOSPITALIZATIONS (YEAR&REASON)		
9.VARICOSITIES/PHLEBITIS							
10.THYROIDDYSFUNCTION							
11.TRAUMA/DOMESTICVIOLENCE					22.ANESTHETICCOMPLICATIONS		
12.HISTORYOFBLOODTRANSFUS					23.HISTORYOFABNORMALPAP		
	AMT/DAY PREPREG	AMT/DAY PREPREG	#YEARS USE		24.UTERINEANOMALY/DES		
13.TOBACCO					25.INFERTILITY		
14.ALCOHOL					26.RELEVANTFAMILYHISTORY		
15.STREETDRUGS					27.OTHER		

COMMENTS: _____

ACOG ANTEPARTUM RECORD (FORM A)

CORNERSTONE CLINIC

JOHN P. RAMSAY, M.D.
SUZANNE E. ELLISON, M.D.
MATTHEW J. HOERMANN, M.D.
KRISTI A. STAFFORD, M.D.
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Confidential

CONSENT FOR BLOOD TESTS

I have been informed that my blood will be tested in order to detect whether or not I have antibodies and/or antigens in my blood to the Human Immunodeficiency Virus (HIV), which is the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood and using a substance to test the blood.

I have been informed that the test results may, in some cases, indicate that a person has antibodies and/or antigens to the virus when the person does not (false positive), or that it may fail to detect that a person has antibodies to the virus when the person has antibodies (false negative). I understand that in order to diagnose AIDS, other clinical evidence must be used in conjunction with this blood test.

I also consent to be tested for Hepatitis B Virus and Hepatitis C Virus at this time.

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks and alternative tests, I may ask those questions before I decide to consent to the blood test.

I understand that the results of the blood test are confidential and will only be released to those healthcare practitioners directly responsible for my care and treatment, and to others as required by law. I further understand that no additional release of the results will be made without my written authorization.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood tests and release of results and have had all of my questions answered. Further, I acknowledge that I have given consent for the performance of a blood test to detect antibodies to the Human Immunodeficiency Virus (AIDS).

Signed: _____

If signed by other than the patient, indicate relationship:

_____

Date _____, 20 _____

_____
Witness