

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST MIDDLE

HOSPITAL OF DELIVERY \_\_\_\_\_

ID# NEWBORN'S PHYSICIAN \_\_\_\_\_ REFERRED BY \_\_\_\_\_

<b>FINAL EDD</b> _____				<b>PRIMARY PROVIDER/GROUP</b> _____			
BIRTHDATE	AGE	RACE	MARITAL STATUS	ADDRESS			
			S M W D SEP				
OCCUPATION			EDUCATION	ZIP	PHONE	(H)	(O)
<input type="checkbox"/> HOMEMAKER <input type="checkbox"/> OUTSIDE WORK <input type="checkbox"/> STUDENT Type of Work _____			(LAST GRADE COMPLETED)	INSURANCE CARRIER/MEDICAID# _____			
HUSBAND/FATHER OF BABY			PHONE	EMERGENCY CONTACT		PHONE	
TOTAL PREG	FULL TERM	PREMATURE	AB.INDUCED	AB.SPONTANEOUS	MULTIPLE BIRTHS	ECTOPICS	LIVING

**MENSTRUAL HISTORY**

LMP  DEFINITE  APPROXIMATE (MONTH KNOWN) MENES MONTHLY  YES  NO FREQUENCY: Q \_\_\_\_\_ DAYS MENARCHE \_\_\_\_\_ (AGE ONSET)

UNKNOWN  NORMAL AMOUNT/DURATION PRIOR MENES \_\_\_\_\_ DATE ON BCP AT CONCEPT.  YES  NO hCG+ \_\_\_\_ / \_\_\_\_ / \_\_\_\_

FINAL \_\_\_\_\_

**PAST PREGNANCIES (LAST SIX)**

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

**PAST MEDICAL HISTORY**

	O Neg +Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT	O Neg +Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES				16. D(Rh)SENSITIZED
2. HYPERTENSION				17. PULMONARY(TB,ASTHMA)
3. HEARTDISEASE				18. ALLERGIES (DRUGS)
4. AUTOIMMUNE DISORDER				19. BREAST
5. KIDNEY DISEASE/UTI				20. GYNSURGERY
6. NEUROLOGIC/EPILEPSY				21. OPERATION/HOSPITALIZATIONS (YEAR & REASON)
7. PSYCHIATRIC				
8. HEPATITIS/LIVER DISEASE				
9. VARICOSITIES/PHLEBITIS				22. ANESTHETIC COMPLICATIONS
10. THYROID DYSFUNCTION				23. HISTORY OF ABNORMAL PAP
11. TRAUMA/DOMESTIC VIOLENCE				24. UTERINE ANOMALY/DES
12. HISTORY OF BLOOD TRANSFUS				
	AMT/DAY PREPREG	AMT/DAY PREPREG	# YEARS USE	
13. TOBACCO				25. INFERTILITY
14. ALCOHOL				26. RELEVANT FAMILY HISTORY
15. STREET DRUGS				27. OTHER

COMMENTS: \_\_\_\_\_

SYMPTOMS SINCE LMP

	YES	NO		YES	NO
1.PATIENT'S AGE (35 OR OLDER)			12.MENTAL RETARDATION/AUTISM		
2.THALASSEMIA(ITALIAN,GREEK,MEDITERRANEAN,ORASIAN BACKGROUND)MCV<80			IF YES,WAS PERSON TREATED FOR FRAGILE X?		
3.NEURAL TUBE DEFECT (MENINGOMYELOCELE,SPINABIFIDA,ORANENCEPHALY)			13.OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4.CONGENITAL HEART DEFECT			14.MATERNAL METABOLIC DISORDER (EG.INSULIN DEPENDENT DIABETES,PKU)		
5.DOWN SYNDROME			15.PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6.TAY-SACHS (EG.JEWISH,CAJUN,FRENCH-CANADIAN)			16.RECURRENT PREGNANCY LOSS OR A STILLBIRTH		
7.SICKLE CELL DISEASE OR TRAIT(AFRICAN)			17.MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8.HEMOPHILIA			IF YES,AGENT(S)		
9.MUSCULAR DYSTROPHY			18.ANY OTHER		
10.CYSTIC FIBROSIS					
11.HUNTINGTON CHOREA					

COMMENTS/COUNSELING \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

INFECTION HISTORY	YES	NO		YES	NO
1.HIGH RISK HEPATITIS B/IMMUNIZED?			4.RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		
2.LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5.HISTORY OF STD.GC.CHLAMYDIAHPV.SYPHILIS		
3.PATIENT OR PARTNER HAS HISTOR YOF GENITAL HERPES			6.OTHER (SEE COMMENTS)		

COMMENTS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

INTERVIEWER'S SIGNATURE \_\_\_\_\_

**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).

Patient Name (Print): \_\_\_\_\_ DOB \_\_\_\_\_

Patient Signature: \_\_\_\_\_  
(Or signature of legally authorized representative)

If legally authorized representative, indicate relationship:

\_\_\_\_\_

Date: \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_

Witness