DATE _____

NAME _____
LAST FIRST MIDDLE

_____ HOSPITAL OF DELIVERY _____

ID# NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTHDATE	AGE	RACE	MARITAL STATUS S M W D SEP	ADDRESS
OCCUPATION ☐ HOMEMAKER ☐ OUTSIDE WORK ☐ STUDENT Type of Work			EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)
				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							
7.PSYCHIATRIC							
8.HEPATITIS/LIVER DISEASE					21.OPERATION/HOSPITALIZATIONS (YEAR & REASON)		
9.VARICOSITIES/PHLEBITIS							
10.THYROID DYSFUNCTION							
11.TRAUMA/DOMESTIC VIOLENCE					22.ANESTHETIC COMPLICATIONS		
12.HISTORY OF BLOOD TRANSFUS					23.HISTORY OF ABNORMAL PAP		
	AMT/DAY PREPREG	AMT/DAY PREPREG	# YEARS USE		24.UTERINE ANOMALY/DES		
13.TOBACCO					25.INFERTILITY		
14.ALCOHOL					26.RELEVANT FAMILY HISTORY		
15.STREET DRUGS					27.OTHER		

COMMENTS: _____

ACOG ANTEPARTUM RECORD (FORM A)

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			IFYES,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					
9.MUSCULAR DYSTROPHY			IF YES,AGENT(S)		
10.CYSTIC FIBROSIS			18.ANY OTHER		
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** _____

FREDERICKSBURG FAMILY CLINIC, PA
d/b/a/ CORNERSTONE CLINIC

514 W. WINDCREST ST., FREDERICKSBURG, TX 78624, 830.997.0330
815 FRONT ST., COMFORT, TX 78013, 830.995.5633

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