JAMES J. DALLA RIVA, MD, FACOG
THOMAS M. HULSEN, MD, FACOG
MONICA E. MAJOR-HARRIS, APRN, FNP-BC
OBSTETRICS & GYNECOLOGY
6812 STATE ROUTE 162, SUITE 301
MARYVILLE, ILLINOIS 62062
618/288-5699 * 618/288-5797 (FAX)

Dear Patient,

Thank you for choosing Dalla Riva and Hulsen Obstetrics and Gynecology for your health care needs. Enclosed you will find registration and history forms for you to fill out and bring with you to your scheduled appointment. These forms are for both new and established patients. Please fill all forms out to the best of your ability. Please check with your insurance company and/or primary care physician prior to your visit if your insurance requires a referral. Please bring your current insurance card along with your copayment to your visit. If you have any questions regarding your insurance coverage, benefits, or copayments, please contact the number on your insurance card prior to your visit.

Please be advised that our office has recently relocated. We are now located in Anderson Hospital Physicians Office Building #2, Suite 301. Our telephone number remains the same.

Thank you,

Karen L Copeland, CPC, RMC

Karen L. Copeland, CPC, RMC
Office Manager

072012

James J. Dalla Riva, MD, FACOG
Thomas M. Hulsen, MD, FACOG
OBSTETRICS AND GYNECOLOGY
6810 State Route 162, Suite 301
Maryville, IL 62062
(618) 288 5699 FAX (618) 288 5797

GENERAL HISTORY

Name:		Referred By:		Date:
Age:	Date of Birth :		Marital Status :	
Occupation:		Occupation Concerns:		
Blood Type:	Rh Factor:			
Health Habits:	Caffeine:	Tobacco:	Alcohol:	Recreational Drugs:
Date last period began:		Cycle length:	Duration of bleeding:	
Last Pap Smear:		Normal/Abnormal	Last Mammogram:	

Circle if you have ever had any of the following problems:

Abnormal Pap Smear, Bleeding Between Periods, Breast Lumps, Extreme Menstrual
Pain, Hot Flashes, Nipple Discharge, Painful Intercourse, Vaginal Discharge, or any
other problem not listed:
Allergies to Medications or Other Substances:
Chronic Illness:
Hospitalizations/Surgeries (list reason, type of surgery, and date)

PREGNANCY RECORD:

NO.	MONTH	YEAR	NAME	BIRTH WEIGHT	SEX	WEEKS PREGNANT	HOURS IN LABOR	TYPE OF DELIVERY & COMPLICATIONS

MEDICATIONS

Please list medications you are currently taking:

_____

_____

Thomas M. Hulsen, MD, FACOG
OBSTETRICS AND GYNECOLOGY
Health History Continued

SYMPTOMS

Please circle symptoms you currently have or have had in the past year.

General – Chills, Depression, Dizziness, Fainting, Fever, Forgetfulness, Headache, Loss of Sleep, Loss of Weight, Nervousness, Numbness, Sweats
Muscle/Joint/Bone (pain, weakness, numbness) – Arms, Back, Feet, Hands, Hips, Legs, Neck, Shoulders
Genito-Urinary – Blood in Urine, Frequent Urination, Lack of Bladder Control, Painful Urination
Gastrointestinal – Appetite Poor, Bloating, Bowel Changes, Constipation, Diarrhea, Excessive Hunger, Excessive Thirst, Gas, Hemorrhoids, Indigestion, Nausea, Rectal Bleeding, Stomach Pain, Vomiting, Vomiting Blood
Cardiovascular – Chest Pain, High Blood Pressure, Irregular Heart Beat, Low Blood Pressure, Poor Circulation, Rapid Heart Beat, Swelling of Ankles, Varicose Veins
Eyes, Ear, Nose, Throat – Bleeding Gums, Difficulty Swallowing, Earache, Ear Discharge, Hay Fever, Hoarseness, Loss of Hearing, Nosebleeds, Persistent Cough, Ringing in Ears, Sinus Problems, Visual Changes
Skin – Easy Bruising, Hives, Itching, Changes in Moles, Rash, Scars, Sores

CONDITIONS

Please circle conditions you have or have had in the past.

AIDS, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding Disorders, Breast Lump, Bronchitis, Bulemia, Cancer, Cataracts, Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart Disease, Hepatitis, Hernia, Herpes, High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Pacemaker, Pneumonia, Polio, Psychiatric Care, Rheumatic Fever, Scarlet Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsillitis, Tuberculosis, Typhoid Fever, Ulcers, Vaginal Infections Venereal Disease

FAMILY HISTORY

Fill in the health information about your family.

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
SISTERS				
BROTHERS				

Please circle and list relationship to you if your blood relatives had any of the following:

Arthritis, Gout _____
Cancer _____
Diabetes _____
High Blood Pressure _____
Tuberculosis _____
Osteoporosis _____

Asthma, Hay Fever _____
Chemical Dependency _____
Heart Disease, Strokes _____
Kidney Disease _____
Other disease not listed _____
_____
_____

JAMES J. DALLA RIVA, MD, FACOG * THOMAS M. HULSEN, MD, FACOG

PATIENT REGISTRATION INFORMATION

So we may accurately file claims to your insurance company, please fill in ALL blanks. Please present insurance cards to the Receptionist upon arrival.

Today's Date_____ Referred By_____

Primary Care Physician_____

Name_____
(First) (Middle) (Last)

Address_____
(Street) (City) (State) (Zip Code)

Home Phone Number_____ Cell Phone Number_____

Marital Status: M S W D Date of Birth_____ Age_____

Social Security #_____ Drivers License #_____

Patient's Employer or School_____

Employer's Address_____ Phone Number_____

Full Time/Part Time/Temporary_____ Occupation_____

GUARANTOR INFORMATION (Who Insurance is through)

Spouse/Parent Name_____

Address_____

Phone Number_____ Date of Birth_____ SS#_____

Spouse/Parent Employer_____

Address_____ Phone Number_____

INSURANCE INFORMATION

Primary Insurance_____ Subscriber Name_____

ID Number_____ Group Number_____

Secondary Insurance_____ Subscriber Name_____

ID Number_____ Group Number_____

EMERGENCY CONTACT

Name_____ Home Phone Number_____

Address_____ Work/Cell Phone Number_____

JAMES J. DALLA RIVA, M.D., F.A.C.O.G.
THOMAS M. HULSEN, M.D., F.A.C.O.G.

FINANCIAL POLICY

(Please read and sign where indicated)

I, the undersigned, have insurance coverage with _____ and assign directly to James J. Dalla Riva, MD all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronically. I hereby recognize and accept full responsibility for the timely payment of any balances remaining after such benefits have been paid. I have read and I understand this policy and the financial policy of this office.

_____ _____

SIGNATURE DATE

MEDICARE PATIENTS

(Please read and sign where indicated)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to James J. Dalla Riva, MD/Thomas M. Hulsen for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charged determination of the Medicare carrier.

_____ _____

SIGNATURE DATE

DALLA RIVA OBSTETRICS & GYNECOLOGY
James J. Dalla Riva, M.D., F.A.C.O.G.
Thomas M. Hulsen, M.D., F.A.C.O.G.

PAYMENT POLICY

Thank you for choosing us as your ob/gyn providers. We are committed to providing you with quality and affordable health care. Please carefully read our payment policy. After reading this policy, please ask any questions you may have, and sign in the space provided. A copy of this policy will be provided to you upon request.

1. **Self-pay.** Please be aware that you will be responsible to pay the amount due at the time of service. Before seeing the provider, make sure you have the available funds with you to pay for the services provided. If you need an estimated cost, please ask to speak to our billing department prior to your visit. We accept cash, personal check, visa and MasterCard.
2. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate in but do not have an up-to-date insurance card, payment in full for each visit is required until we receive your up-to-date insurance card. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
3. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
4. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit unless other arrangements are made with our billing department.
5. **Proof of insurance.** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance.
6. **Claim submission.** We will submit your claims and assist you in any way we reasonable can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and the insurance company.
7. **Coverage changes.** If your insurance company changes, please notify us before your next visit. If you fail to inform us of the change, you will be responsible for the bill.

(OVER)

8. **Nonpayment.** If your account is over 90 days past due, you may receive a letter stating you have 20 days to pay your balance. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. We may also discharge you as a patient from this practice. If this is to occur, we will notify you by mail that you have 30 days to find an alternate medical provider. During that 30-day period, our providers will only be available to treat you on an emergency basis.
9. **Missed Appointments.** Our policy is to charge for missed appointments not canceled within a reasonable timeframe. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature Date

_____

Witness

James J. Dalla Riva, MD, FACOG
Thomas M. Hulsen, MD, FACOG
Monica E. Major-Harris, APRN, FNP-BC

6812 State Route 162, Suite 301
Maryville, IL 62062
p: 618.288.5699
f: 618.288.5797

Dear Patient:

At DallaRiva and Hulsen OBGYN, we pride ourselves on offering our patients the most advanced preventative care available. As of August 2012, in accordance with the recommendations of the American College of Obstetrics and Gynecology and the American Society For Colposcopy and Cervical Pathology, we will be performing the following tests as part of our annual well woman visits:

Age 21 – 25
Pap Smear
Chlamydia/Gonorrhea Screening
If Pap is Abnormal – High Risk HPV Testing

Age 26 – 29
Pap Smear
If Pap is Abnormal – High Risk HPV Testing

Age 30 – 64
Pap Smear
High Risk HPV Testing
If Pap is Normal and HPV is Positive – Testing For HPV Types 16/18

HPV Testing in conjunction with a Pap Test for cervical cancer screening, can show with nearly 100% certainty that you do not have cervical cancer. Here are a few things to know about cervical cancer screening:

- Most women will have HPV at some point during their lives but very few will develop cervical cancer
- Cervical cancer develops if an HPV infection persists for many years
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high- risk HPV infection. The HPV test looks for HPV infection.
- Women who test negative for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
- Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- Your HPV status is not a reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.

Most insurance companies pay for HPV testing in women 30 and older. If yours does not, you may receive a bill from the Lab. If you do not want any of the testing listed above, please speak with your provider at your next well woman visit. Thank you and we look forward to seeing you soon.

www.DallaRivaMedical.com

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth: _____ Date completed: _____

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your **mother's or father's side**). Behind each statement, please list the relationship to you of the individual diagnosed. You and the following family members should be considered: mother, father, brother, sister, children, maternal/paternal aunts and uncles, nieces, nephews, first cousins, maternal/paternal grandparents and their **age at diagnosis**. This is a screening tool for the common features of hereditary cancer syndromes.

			RELATIONSHIP	AGE AT DIAGNOSIS
BREAST AND OVARIAN CANCER				
Y	N	- Breast cancer at any age		
Y	N	- Ovarian cancer at any age		
Y	N	- Breast cancer in both breasts or multiple primary breast cancers		
Y	N	- Both breast & ovarian cancer		
Y	N	- Pancreatic cancer with breast or ovarian cancer		
Y	N	- Male breast cancer		
Y	N	- 2 or more breast or ovarian cancers (in an individual or a family)		
Y	N	- Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer		
Y	N	Triple negative breast cancer (ER-, PR-, HER2-)		
COLON AND UTERINE CANCER				
Y	N	- Uterine cancer before age 60		
Y	N	- Colorectal cancer before age 60		
Y	N	- Both uterine & colorectal cancer (in an individual or family)		
Y	N	- 2 or more uterine or colorectal cancers (in an individual or a family)		
Y	N	- Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family)		
Y	N	- 10 or more colon polyps found in a lifetime		
Y	N	- Have you or a family member ever been tested for hereditary cancer syndromes?		

☐ Candidate for further risk assessment and/or genetic testing ☐ Patient offered genetic testing

☐ Information given to patient to review ☐ **Accepted** ☐ **Declined**

☐ Follow up appointment scheduled Date: _____ ☐ Not a Candidate for genetic testing

_____ _____

Patient's Signature Date Health Care Provider's Signature Date

PF-1000 Notice of Privacy Practices / James J. Dalla Riva OB/GYN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **DALLA RIVA OB/GYN**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

PF-2000 Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Dalla Riva OB/GYN** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Dalla Riva OB/GYN may or may not agree to restrict the use or disclosure of your protected health information.

If Dalla Riva OB/GYN agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Dalla Riva OB/GYN reserves the right to modify the privacy practices outlined in the notice.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Fund raising. Unless you request us not to, we may use your name and address to support our fund raising efforts.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

DALLA RIVA, OB/GYN Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **OUR RECEPTIONIST** or our **OFFICE MANAGER**.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

OFFICE MANAGER
DALLA RIVA OB/GYN
6810 STATE ROUTE 162, SUITE 301
MARYVILLE, IL 62062

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name of the person you can contact for further information concerning our privacy practices is our Office Manager, Karen L. Copeland, CPC

Effective Date

This Notice is effective on or after APRIL 14, 2003

PRIVACY PRACTICES ACKLNOWLEDGEMENT

I have received the notice of Privacy Practices of Dalla Riva Obstetrics and Gynecology and I have been provided an opportunity to review it.

_____

(Print Name)

_____

(Signature of patient)

_____

(Date)

PREGNANCY FLOW SHEET

LAST NAME:_____ FIRST _____ MI____ PT#____

LMP: _____ EDC: _____
Month Day Year Month Day Year

ALLERGIES_____

PROBLEMS AND COMPLICATIONS

DATE	PROBLEM / CONDITION	PLAN / ACTION

FLOW CHART

DATE	WT	BP	UA	EGA	FH	FHT	FM	PRES-ENT	EDE-MA	COMMENTS / COMPLAINTS / TREATMENT	F/U	MD

RISKS, PROBLEMS AND PLANS OF THIS PREGNANCY

LAST NAME:_____ FIRST_____ MI_____ PT#____

LMP: _____ EDC: _____
Month Day Year Month Day Year

Normal ☐ Abnormal ☐

INITIAL LABORATORY RESULTS DATE _____

BLOOD TYPE / RH: PATIENT:_____ FATHER_____
HEMOGLOBIN:_____ HEMATOCRIT:_____ WBC:_____
URINE: GLUCOSE:_____ PROTEIN:_____ BLOOD:_____ CULTURE:_____
ANTIBODY SCREEN:_____ SICKLE CELL:_____
SEROLOGY:_____ RUBELLA TITER:_____
PAP TEST:_____ CERVICAL CULTURE:_____
TAY SACHS:_____ GC:_____
CHLAMYDIA:_____ ALPHA FETO PROTEIN:_____
HIV:_____ HEPATITIS B:_____
ULTRASOUND: DATE:_____ RESULTS:_____
ULTRASOUND: DATE:_____ RESULTS:_____

NOTES

GENETIC STUDY

_____AMNIOCENTESIS DATE:_____ RESULTS_____
_____CHORIONIC VILLI BIOPSY DATE:_____ RESULTS:_____

PREGNANCY HISTORY

LAST CONTRACEPTIVE
Type_____
Date Stopped_____

MENSTRUAL HISTORY
Cycle_____Days Onset Age_____
Length_____Days

LMP: MO_____ DAY____YEAR____
EDC: MO_____DAY____YEAR____

PARA____GRAV_____ AB____S E

# PREG	MO / YR	M / F	WT	GEST WEEKS	HRS LABOR	TYPE OF DELIVERY	DETAIL OF ANY COMPLICATIONS
1							
2							
3							
4							
5							
6							

PLANS TO ATTEND CHILDBIRTH CLASSES YES____NO_____

BIRTHING PLAN:
Babys Doctor:_____
Hospital_____
Anesthesia Planned_____
Sterilization_____
Breast or Bottle_____
Circumcision: YES____NO_____
Additional Request:
_____

POST TERM MANAGEMENT (42 Weeks)
DELIVERY SCHEDULED____YES_____NO
IF NO, TEST ORDERED:
_____
_____
_____
_____

M.D. SIGNATURE AND DATE

GYNECOLOGICAL / OBSTETRICAL HISTORY

LAST NAME:_____ FIRST _____ MI_____ PT#_____

PATIENT – PLEASE COMPLETE

Birthplace | Age | Date of Birth | Race | Marital Status

Your Occupation | Your Education Completed

Baby's Father's Name | Father's Telephone # | Father's Age | Father's Race | Father's Occupation

Person to Contact In Emergency | Telephone # | Alternate Telephone | Address

GENERAL HISTORY – SELF / FAMILY

Please check if you or if any of your relatives have had any of the conditions listed below
IF YOU ARE UNSURE OF ANY CONDITION, PLEASE CIRCLE THAT CONDITION

FAMILY		SELF			FAMILY		SELF		
No	Yes	No	Yes	Condition	No	Yes	No	Yes	Condition
				Cancer					Infertility
				High Blood Pressure					Blood Clots / Varicose Veins
				Rheumatic Fever					Sexually Transmitted Disease
				Lung Disease					Genital Herpes
				Stomach / Bowel Problems					Condylomata (Warts)
				Kidney Disease					Chlamydia
				Urinary Problems, Infections / Malformations					Infectious Diseases:
				Diabetes Mellitus					Hepatitis
				Anemia / Blood Disorders					Tuberculosis
				Other Endocrine / Hormone Disorders					PKU
				Nervous Mental Disorders					DES Exposure
				Convulsive Disorders - Epilepsy					
				Abnormal Babies					
				Genetic Disease					
				Twins					

Does the baby's father, or his family, have any history of abnormal babies or genetic disease? No Yes

HABITS / ENVIRONMENTAL FACTORS

TOBACCO & CAFFEINE

No	Yes	
		Coffee / Tea_____cups / day
		Cola or other caffeine drinks_____/ day
		Cigarettes - Now_____/ day_____/ years
		Cigarettes - Ever_____/ day_____/ years
		Stopped When? _____

ALCOHOL

Alcohol

_____Drinks per day

_____Drinks per week

MISC

	No	Yes	
Are you around cats?			
Do you use a hot tub?			
Do you have a regular exercise routine?			
Do you, or have you, used Drugs (marijuana, cocaine, Meth, LSD)?			

ALLERGIES:_____

PLEASE LIST ALL TIMES YOU HAVE BEEN HOSPITALIZED, OPERATED ON OR SERIOUSLY INJURED

Year	Operation, Illness, Injury	Hospital , City, State

THIS PREGNANCY HISTORY AND PHYSICAL EXAMINATION

LAST NAME:_____ FIRST _____ MI_____ PT#_____

HISTORY SINCE LAST MENSES

No	Yes	Condition
O	O	Headaches
O	O	Abdominal Pain
O	O	Vaginal Discharge
O	O	Vaginal Bleeding
O	O	Edema (specify Area) _____ _____

No	Yes	Condition
O	O	Febrile Episode
O	O	Rubella (German Measles) Exposure
O	O	Other Viral Exposure
O	O	Radiation Exposure Include Dental X-Rays Other_____ _____
O	O	Cocaine, Marijuana Alcohol or Other Recreational Drugs

MEDICATIONS / DRUGS TAKEN SINCE LAST MENSTRUAL PERIOD

No	Yes	
O	O	Fertility (List) _____
O	O	Prescription _____
O	O	Non Prescription _____

PHYSICAL EXAMINATION

TEMP_____PULSE_____ RESP_____/_____HEIGHT_____WEIGHT _____

	Normal	Abnormal
1. HEAD AND NECK		
Ears	O	O
Nose	O	O
Eyes	O	O
Mouth	O	O
Thyroid	O	O
2 THORAX, HEART, LUNGS		
Breast	O	O
Heart	O	O
Rhythm	O	O
Murmurs	O	O
Gallop	O	O
Lungs	O	O
Rales, Rhonchi	O	O
Wheezing	O	O
3. ABDOMEN		
Tenderness	O	O
Masses	O	O
Hernia	O	O
Liver	O	O
Inguinal Nodes	O	O
Surgical Scars	O	O
4. MUSCULOSKELETAL		
Extremities	O	O
Back	O	O
5. SKIN	O	O
6. NEUROLOGICAL	O	O
Deep Tendon Reflexes	O	O
Grade 1 2 3 4		
7. PELVIC		
External Genitalia	O	O
Vagina	O	O
Cervix	O	O
Uterus (Size / Position)	O	O
Adnexa	O	O
8. RECTAL	O	O
9. BONY PELVIS	O	O

PHYSICIAN NOTES

DIAG CONJ._____SHAPE SACRUM_____SS. NOTCH_____

ISCHIAL SPINES_____PUBIC ARCH_____TRANS OUTLET_____

POST SAG. DIAMETER_____COCCYX_____

PELVIC CLASS

- O GYNECOID
- O ANTHROPOID
- O ANDROID
- O PLATYPELLOID

- O ADEQUATE
- O BORDERLINE (EST)
- O CONTRACTED

_____

M.D. SIGNATURE AND DATE

TELEPHONE CALLS

LAST NAME:_____ FIRST _____ MI____ PT#____

DATE	PERSON	QUESTION	ADVICE