OBSTETRIC HISTORY QUESTIONNAIRE

Patient Name: ___________________________  DOB: ___________  Date: ___________

Are you currently pregnant? □ Yes  □ No
If yes, what is your due date?: _______________
What was the first day of your last menstrual period?: _______________

Have you had any problems in the current pregnancy? □ Yes  □ No
If yes, please specify: _____________________________________________________________

Prior pregnancies

_____ Number of pregnancies (not including this one)
_____ Number of full term deliveries
_____ Number of preterm deliveries
_____ Number of pregnancies carried past 4 ½ months [20 weeks]
_____ Number of miscarriages [spontaneous]
_____ Number of voluntary abortions
_____ Number of ectopic [tubal] pregnancies
_____ Number of multiple births
_____ Number of living children

Please fill in the table below for all pregnancies, starting with the first, and include all pregnancies, living or deceased.

<table>
<thead>
<tr>
<th>Year</th>
<th>Weeks</th>
<th>Length of Labor</th>
<th>Weight</th>
<th>Sex (circle one)</th>
<th>Anesthesia</th>
<th>Type of delivery (i.e. vaginal or C/S)</th>
<th>Hospital</th>
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<td>hrs</td>
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</table>

Patient Name: ___________________________  DOB: ___________
Do you drink alcohol?  □ Yes □ No
If yes, how often during the pregnancy ____________________________________________________
How often before pregnancy ________________________________________________________________

Do you use illicit drugs (“street drugs”)?  □ Yes □ No
__ I have never used drugs. __ I used drugs in the past __ I used drugs before pregnancy. __ I am still using drugs.

Drug

How often

Do you have any medical problems?  □ Yes □ No  If yes, please list below.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Patient Name: _____________________________________________     DOB: _____________
MEDICAL HISTORY

Do YOU have, or have you had, any of the following conditions:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Condition</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unexplained Fever</td>
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<td></td>
<td></td>
<td>Vision Problems</td>
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<td></td>
<td></td>
<td></td>
<td>Hearing Loss</td>
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<td></td>
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<td></td>
<td>Ear Infections (other than childhood)</td>
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<td></td>
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<td></td>
<td>Sinus Problems</td>
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<td></td>
<td>Repeated Nosebleeds</td>
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<td></td>
<td>Long Term Sore Throat</td>
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<td></td>
<td></td>
<td></td>
<td>Pneumonia</td>
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<td></td>
<td>Asthma</td>
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<td></td>
<td></td>
<td></td>
<td>Close Contact With Persons(s) With Tuberculosis</td>
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<td></td>
<td>Tuberculosis Vaccine (BCG)</td>
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<td></td>
<td>Unexplained Tuberculosis Skin Test</td>
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<td></td>
<td>Unexplained Cough</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Unexplained Shortness Of Breath</td>
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<td></td>
<td></td>
<td></td>
<td>Other Lung Problems</td>
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<td></td>
<td></td>
<td></td>
<td>Heart Murmur</td>
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<td></td>
<td></td>
<td></td>
<td>Mitral Valve Prolapse</td>
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<td></td>
<td></td>
<td></td>
<td>Other Heart Valve Problems</td>
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<td></td>
<td></td>
<td></td>
<td>Heart Attack</td>
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<td></td>
<td></td>
<td></td>
<td>Heart Disease</td>
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<td></td>
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<td></td>
<td>Unexplained Chest Pains</td>
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<td></td>
<td>Unexplained Fainting</td>
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<td></td>
<td>Irregular Heart Beat</td>
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<td></td>
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<td></td>
<td>Other Heart Problems</td>
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<td></td>
<td></td>
<td></td>
<td>High Blood Pressure in Pregnancy</td>
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<td></td>
<td>High Blood Pressure, Other</td>
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<td></td>
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<td></td>
<td>Raynaud’s Disease, Raynaud’s Phenomenon</td>
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<td></td>
<td></td>
<td>Poor Blood Circulation</td>
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<td></td>
<td></td>
<td>Severe Nausea and Vomiting in Pregnancy</td>
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<td></td>
<td></td>
<td>Severe Nausea and Vomiting Before Pregnancy</td>
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<td></td>
<td>Intestinal Problems (Irritable Colon, Crohn’s Disease, Etc.)</td>
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<td>Dietary Restriction</td>
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<td></td>
<td>Unexplained Recurring Diarrhea</td>
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<td></td>
<td></td>
<td></td>
<td>Constipation Problem</td>
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<td></td>
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<td></td>
<td>Heartburn, Reflux</td>
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<td></td>
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<td></td>
<td>Hepatitis, Yellow Jaundice</td>
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<td></td>
<td></td>
<td></td>
<td>Liver Problems</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Bladder or Kidney infections</td>
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<td></td>
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<td></td>
<td>Kidney Stones</td>
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<td></td>
<td></td>
<td></td>
<td>Problems With Urine</td>
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<td></td>
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<td></td>
<td>Menstrual Problems</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Infertility, Difficulty Getting Pregnant</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Vaginal Infections</td>
</tr>
</tbody>
</table>

Patient Name: _____________________________________________     DOB: _______________
### Do YOU have, or have you had, any of the following conditions:

- **Herpes or a Partner with Herpes**
- **Sexually Transmitted Disease**
- **Pelvic Inflammatory Disease**
- **Gonorrhea**
- **Chlamydia**
- **Syphilis**
- **Genital Warts**
- **HIV Infection, AIDS, or a Partner with HIV/AIDS**
- **Abnormal PAP Smear(s)**
- **Diabetes (High Blood Sugar)**
- **Thyroid Problems**
- **Other Hormone Problem**
- **Epilepsy, Seizure Disorder**
- **Unexplained Drowsiness**
- **Migraine/Cluster Headaches**
- **Other Recurring headaches**
- **Depression**
- **Panic Attack Disorder**
- **Psychiatric/Mental/Emotional/Problems**
- **Skin Problems**
- **Unexplained Hair Loss**
- **Arthritis/Joint Pains**
- **Lupus**
- **Rheumatic fever**
- **Blood Transfusions**
  - If Yes, Date
  - Reason

- **Bleeding Tendency**
- **Blood Clots, Thrombophlebitis**
- **Rh Sensitized**

### Any Previous Surgeries? (include minor or outpatient surgeries such as wisdom tooth removal, D&C, etc.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

### Any allergies to medications?  ☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
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<tbody>
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### Any other Problems

Reviewed by

<table>
<thead>
<tr>
<th>Provider signature</th>
<th>Patient signature</th>
<th>DOB</th>
</tr>
</thead>
</table>
GENETIC/FAMILY HISTORY

How would you describe your ancestry (check all that apply):

- [ ] Caucasian (white)
- [ ] African (black)
- [ ] Hispanic
- [ ] Ashkenazi Jewish
- [ ] Cajun
- [ ] Guamanian
- [ ] Other
- [ ] French Canadian
- [ ] Native American
- [ ] Greek
- [ ] Middle Eastern
- [ ] Hawaiian
- [ ] Unknown Race
- [ ] Samoan
- [ ] Italian
- [ ] Japanese
- [ ] Asian – East Indian
- [ ] Other 2
- [ ] Vietnamese
- [ ] Chinese
- [ ] Cambodian
- [ ] Filipino
- [ ] Other Southeast Asian
- [ ] Laos
- [ ] Taiwanese
- [ ] Korean
- [ ] Ashkenazi Jewish
- [ ] Italian
- [ ] Filipino
- [ ] Asian – East Indian
- [ ] Other 2
- [ ] Guamanian
- [ ] Hawaiian
- [ ] Unknown Race
- [ ] Other
- [ ] Hispanic
- [ ] Greek
- [ ] Cambodian
- [ ] Japanese
- [ ] Other Southeast Asian
- [ ] Chinese
- [ ] Filipino
- [ ] Asian – East Indian
- [ ] Other 2
- [ ] Guamanian
- [ ] Hawaiian
- [ ] Unknown Race
- [ ] Other
- [ ] Other

Are you and the father of this baby blood relative (example: cousins)? [ ] Yes  [ ] No

What is your occupation? __________________________________________________________

What is the name of the father of this baby? ____________________________________________

What is the occupation of the father of this baby? ________________________________________

What is the age of the father of this baby? _________

How would you describe the ancestry of the father of this baby (check all that apply):

- [ ] Caucasian (white)
- [ ] African (black)
- [ ] Hispanic
- [ ] Ashkenazi Jewish
- [ ] Cajun
- [ ] Guamanian
- [ ] Other
- [ ] French Canadian
- [ ] Native American
- [ ] Greek
- [ ] Middle Eastern
- [ ] Hawaiian
- [ ] Unknown Race
- [ ] Samoan
- [ ] Italian
- [ ] Japanese
- [ ] Asian – East Indian
- [ ] Other 2
- [ ] Vietnamese
- [ ] Chinese
- [ ] Cambodian
- [ ] Filipino
- [ ] Other Southeast Asian
- [ ] Laos
- [ ] Taiwanese
- [ ] Korean
- [ ] Ashkenazi Jewish
- [ ] Italian
- [ ] Filipino
- [ ] Asian – East Indian
- [ ] Other 2
- [ ] Guamanian
- [ ] Hawaiian
- [ ] Unknown Race
- [ ] Other
- [ ] Hispanic
- [ ] Greek
- [ ] Cambodian
- [ ] Japanese
- [ ] Other Southeast Asian
- [ ] Chinese
- [ ] Filipino
- [ ] Asian – East Indian
- [ ] Other 2
- [ ] Guamanian
- [ ] Hawaiian
- [ ] Unknown Race
- [ ] Other
- [ ] Other

Is the father of this baby your partner? [ ] Yes  [ ] No

Comments: ______________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Patient Name: ____________________________     DOB: _____________
Does the father of the baby, or any close relative of yours or the father, have any of the following (if yes, please note who):

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Yes</th>
<th>No</th>
<th>Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Thalassemia MCV&lt;80</td>
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<tr>
<td>2. Neural Tube Defect (Spina Bifida, or Anencephaly)</td>
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<td>3. Congenital Heart Defect</td>
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<td>4. Down Syndrome</td>
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<tr>
<td>5. Tay-Sachs</td>
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<tr>
<td>6. Sickle Cell Disease or Trait</td>
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<tr>
<td>7. Hemophilia or bleeding Problems (Type: )</td>
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<tr>
<td>8. Muscular Dystrophy</td>
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<tr>
<td>9. Cystic Fibrosis</td>
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<tr>
<td>10. Canavan Disease</td>
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<tr>
<td>11. Mental Retardation/Autism/Learning disorder</td>
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<tr>
<td>If Yes, Tested for Fragile X</td>
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<tr>
<td>12. Huntington Chorea</td>
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<tr>
<td>13. Other inherited genetic or chromosomal disorder</td>
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<tr>
<td>14. Maternal Metabolic Disorder (i.e. Insulin-Dependent Diabetes, PKU)</td>
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<tr>
<td>15. Patient or baby’s father had a child with birth defects not listed above</td>
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<td>16. Recurrent pregnancy loss, or stillbirth</td>
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<tr>
<td>17. Blindness or deafness</td>
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<tr>
<td>18. Bone or skeletal disorder</td>
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<tr>
<td>19. Breast, ovarian or colon cancer</td>
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<tr>
<td>20. Kidney disorder</td>
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<tr>
<td>21. Do any of your parents, siblings, or children have diabetes</td>
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<td>22. Blood clots/stroke</td>
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<tr>
<td>23. Anything else that seems to run in the family</td>
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</tbody>
</table>

Reviewed by______________________________________________________

Provider signature ___________________________ Patient signature ___________________________

Patient Name: _____________________________________________     DOB: _____________
What is Ultrasound?

Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta, and baby making echoes which a computer converts into detailed images. In essence, an ultrasound is a series of pictures of the baby and organs in the mother’s pelvis.

Is Ultrasound safe?

There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either the mother or the baby when ordinary power is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

Does a normal Ultrasound prove that my baby will have no abnormalities?

Ultrasound examinations can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the bay and the baby’s organs, but does not give complete information about the function of the baby’s organs or tell us that the baby is completely “healthy”. Abnormalities of brain function such as mental retardation cannot be detected by ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities that can appear later in pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal.

Can Ultrasound determine if there are chromosomal abnormalities?

Findings on an ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently the only way to assess the baby’s chromosomes with certainty is to actually obtain a sample of the baby’s cells by amniocentesis, chorionic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities either because of the mother’s age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby’s chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasound, please do not hesitate to ask the ultrasound technologist, perinatologist, or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

Patient/Guardian Signature __________________________ Date ______________

Printed Name ______________________ Date of Birth ______________________

Patient Name: ______________________ DOB: __________
AUTHORIZATION FOR VERBAL RELEASE OF PROTECTED HEALTH INFORMATION AND PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child’s healthcare provider will use his/her judgment in sharing information in order to foster continuity of care. The release of copies of medical records will require a signed HIPPA-compliant authorization. This permission will be considered on-going until I indicate otherwise, or detail express limitations in writing.

PHI may be released and spoken around the following individuals or additional entities:

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
<th>DATE/INITIALS</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

The Staff of the Practice has my permission to leave messages concerning treatment (Lab Results, Prescription Information, Appointment Reminders/Times, Call Back Requests) on the following numbers. Additionally, the practice now has the ability to send appointment reminders via “Test Message”. Please circle “Text” if preferred. *standard rates may apply

(____) _____ -________ cell / text/ work / home
(____) _____ -________ cell / text/ work / home

Our Notice of Privacy Practices ("Notice") provides information about 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients. Federal Regulation requires that we give our patients or their representatives notice before signing this acknowledgment. If you have any questions about your rights or our privacy practices, please send an email to Privacy_Officer@Mednax.com or a letter to:

Privacy Officer
MEDNAX Services, Inc.
1301 Concord Terrace
Sunrise, FL  33312

By signing below, you are only acknowledging that you have been provided immediate access to our additional notice as is posted in the office.

__________________________   ____________________
Signature of Patient or Authorized Representative     Date

__________________________   ____________________
Patient’s Printed Name

__________________________   ____________________
Print Name of Authorized Representative      Date
CONSENT FOR TREATMENT

I hereby give consent to Mednax Medical Group, Inc. dba Atlanta Maternal Fetal Medicine to provide whatever treatment they may deem necessary to me.

_______________________________________________________   ______________
Signature of patient or responsible party, if minor          Date

Patient Name: ___________________________________________   ______________

PHARMACY INFORMATION

Name of Pharmacy: _____________________________________________________________

Address: _____________________________________________________________________

City: ________________________________  State: ________________________________

Phone Number: _______________________  Fax Number: _________________________
Screening for ZIKA Exposure During Pregnancy

Patient Name: ________________________________  DOB: ____________
Contact Phone Number: _____________________________  Today’s Date: ____________

Patient

1. Have you or your partner traveled to Miami Dade County, Florida, the Caribbean, South America, Central America, Mexico, Pacific Islands, or other country with Zika activity during the current pregnancy?

   For update list of countries/territories, check:


   □ If yes, specify country ____________________________
   Dates traveled ____________________________

Patient

2. If you or your partner have traveled to any of the countries or regions above, have you had any of the following symptoms either during your travel or within 2 weeks of return from travel?

   Check all that apply:

   _____ Fever
   _____ Maculopapular rash (flat, red area on skin covered with confluent bumps)
   _____ Arthalgia (joint pain)
   _____ Conjunctivitis (“pink eye” or eye infection)

The CDC is recommending against travel to many countries during pregnancy.

If you answered “Yes” to any of the above questions, please discuss this with the physician or nurse practitioner at your visit today.

Because guidelines are changing quickly, please be sure you have provided us with your phone contact information.