Women & Children First
FINANCIAL POLICY

Women & Children First ("WCF") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements in healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

- **INSURANCE:** We participate with many insurance companies. It is your responsibility to determine whether we are in network with your insurance company. If we do participate with your insurance company, all services performed in our office will be submitted to them, unless we have received prior notification of non-covered services. Insurance contracts require collection of any copays at the time of the visit. Any uncovered services or deductibles are the responsibility of the Parent / Legal Guardian / Guarantor of the Patient.

- **PAYMENT FOR SERVICES PERFORMED:** For your convenience, our office accepts Visa, MasterCard, Discover, American Express, cash, check, money order, or cashier's checks. All payments are expected at the time of service and any outstanding balances are due within thirty (30) days, unless other arrangements have been made with our office. All balances that reach one hundred twenty (120) days past due will be sent to a collection agency. Any patient whose account has been sent to collections, or which should have been sent to collections for non-payment, will not be extended further credit.

- **Payment in full of any past due balances from all clinics and The Collection Bureau of Kerrville is required prior to being seen for any future appointments in our office.**

- **APPOINTMENT POLICY:** Appointments will be made by the receptionist. **The Administrator reserves the right to contact the patient prior to the appointment and change or cancel it if the patient's account is past due or seriously outside the terms.** In addition, services incurred that day must be paid. Proper payment will have to be arranged with the Business Office before the appointment can be honored.

- **MISSED APPOINTMENT POLICY:** Our clinics will charge Parents / Legal Guardians / Guarantors of patients who miss their appointments without notifying the office within 24 hours of their scheduled appointment. The fee charged will be $25.00. Patient / Legal Guardians / Guarantors will be billed directly for this charge and payment is expected within thirty (30) days of the receipt of the bill. Future appointments may not be booked until the fee is paid.

WCF firmly believes that a good patient / physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification about these policies, **please call us at (830) 997-5964.**

Women & Children First

PROVIDER NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to [Women & Children First], including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. **Utilization Review.** We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. **Credentialing and Peer Review.** We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. **Appointment Reminders and Health Related Benefits and Services**. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. **Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. **Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. **To Avert an Imminent Threat of Injury to Health or Safety.** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. **Research.** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is “de-identified.”

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary, to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine

the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. **Inmates.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. **Marketing of Related Health Services.** We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. **Fundraising.** We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. **Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. **Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. **Psychotherapy Notes, Marketing and Sale of Medical Information.** Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. **Right to Revoke Authorization**. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Women & Children First
Attn: HIPAA Officer
816 Reuben Street
Fredericksburg, TX 78624
(830) 997-3132

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

Women & Children First
OB / GYN CONSENT FORM

Patient Name: _____ Date of Birth: _____ / _____ / _____

Assignment of Benefits: I authorize Women and Children First ("WCF") to submit claims on my behalf directly to Medicare / Medicaid / my private health insurance carrier. This means that WCF will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Initials: _____

Consent for Treatment: I consent for WCF to administer treatments, tests and / or diagnostic tests to treat my / the patient's injury / illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I / the patient receives. In compliance with state law, if another individual is accidentally exposed to my / the patient's blood or body fluids (BFF); or if a medical or surgical procedure could expose another individual to my / the patient's BBF, WCF may have such BBF tested for human immunodeficiency infection (HIV / AIDS) at WCF's expense.

I / We, being the parent(s) or legal guardian(s) of the above-named minor authorize the physician(s) at WCF to examine and / or treat my dependent. I understand that I am financially liable for all charges incurred for same.

Initials: _____

Electronic Prescription: I understand WCF utilizes electronic prescribing technology. This technology operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. This technology also provides prescription data on any medications, known as medication history, which are prescribed to me / the patient.

Initials: _____

Communications: By providing contact information, I authorize WCF, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home / cellular / employment telephone; leave voice, text, or email messages; and use pre-recorded / artificial / voice messages and /or auto-dialing devices in connection with any communication to me.

What is your preferred contact number? _____

Initials: _____

Involvement of Others in Care: I authorize WCF to discuss my / the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my / the patient's needs. **Initials:** _____

Patient Financial Policy

I have read and fully understand the financial policy set for WCF and I agree to the terms of the financial policy. I also understand that the terms of this policy may be amended by WCF at any time, without prior notification of the Parent / Legal Guardian / Guarantor of the patient.

Initials: _____

Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and closed. I understand that I am entitled to a copy of this document.

Initials: _____

_____

Print Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

Women & Children First

OB/GYN PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Would you like to be web-enabled? ☐ Yes ☐ No

Main Contact #: _____ Alternate #: _____ Work #: _____

Date of Birth: ____/____/_____ SS# (optional): _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation: _____

If Married: Spouse's Name: _____ Spouse's Date of Birth: ____/____/_____

Main Contact #: _____ Alternate #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Other Patient Information

Which racial category does the patient most closely identify with?

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic

☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ Other: _____

Ethnicity: What is the patient's ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is the patient's language of preference? ☐ English ☐ Spanish ☐ Other: _____

Insurance Information

Primary Insurance: _____ Policy / ID#: _____

Name of Policy Holder: _____ DOB: ___/___/_____ Group/Acct #: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance: _____ Policy / ID #: _____

Name of Policy Holder: _____ DOB: ___/___/____ Group / Acct #: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Complete Only If Patient is a Minor

Parent / Guardian Name: _____ Relationship: _____

Parent / Guardian Name: _____ Relationship: _____

Sibling: _____ DOB: ___/___/_____ Sibling: _____ DOB: ___/___/____

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Patient Addressograph

OBSTETRIC MEDICAL HISTORY

Name:

LAST FIRST MIDDLE

Date Form Completed: _ _

Father of the Baby:

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

Personal Health History

1. ☐ Yes ☐ No Have you ever had an allergic reaction to a medication or vaccine component?

If yes, please list: _____

_____

Any other allergies or reactions? _____

_____

2. Please mark any condition that you have or have had in the past:

- ☐ Epilepsy
- ☐ Headaches
- ☐ Thyroid Disorder
- ☐ Breast Disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Anemia
- ☐ von Willebrand disease or other bleeding disorders
- ☐ Blood Clotting Disorder (eg, Phlebitis/Thrombophilia)
- ☐ Blood Transfusion
- ☐ Gastrointestinal Illness
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Recurrent Urinary Tract Infections
- ☐ Gestational Diabetes
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Arthritis or Lupus
- ☐ Skin Disorders
- ☐ Prior Pre-term Birth
- ☐ Group B Streptococcus In Prior Pregnancy
- ☐ Herpes
- ☐ Sexually Transmitted Infections
- ☐ HIV/AIDS
- ☐ Frequent Infections
- ☐ Psychiatric Illness
- ☐ Depression/Postpartum Depression
- ☐ Eating Disorder
- ☐ Other: _____

Describe, if needed: _____

_____

3. Please indicate any surgery or hospitalization that you have had and the date:

4. Please describe any health problems or symptoms that you are having at this time:

5. ☐ Yes ☐ No Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

6. ☐ Yes ☐ No Do you have any objections to any form of medical treatment (eg, blood transfusion)?

If yes, please describe: _____

Exposures Affecting Health

1. ☐ Yes ☐ No Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped? If yes,
   how many packs per day? _____ If former smoker/user, when did you quit? _____

2. ☐ Yes ☐ No Do you drink alcoholic beverages now or did you before you became pregnant?If
   yes, please indicate number of drinks per week: _____
   What type of drinks? _____

3. Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines:
   _____
   _____

4. ☐ Yes ☐ No Have you used any street drugs since your last menstrual period (eg, cocaine, marijuana, opioids)? If
   yes, please indicate number of uses per week: _____
   What type of drugs? _____

5. ☐ Yes ☐ No Do you have any reason to believe you or your partner may have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs?

6. ☐ Yes ☐ No Have you been exposed to chemicals (eg, pesticides, lead, hazardous material/agents) or radiation (eg, X-rays) since you became pregnant? If yes,
   please describe: _____

7. ☐ Yes ☐ No Are you on a restricted diet?
   If yes, please describe: _____

8. ☐ Yes ☐ No Have you or your partner recently traveled outside of the United States?If
   yes, please describe: _____

Gynecologic Health History

1. When was your last Pap test? _____
   ☐ Yes ☐ No Have you ever had an abnormal pap test? If
   yes, when and how were you treated? _____
   _____
   What was the diagnosis? _____
   ☐ Yes ☐ No Did you have any procedures on your cervix for treatment (eg, LEEP [loop electrosurgical excision procedure] or cold knife or laser conization)? Have
   ☐ Yes ☐ No you ever had HPV?
   ☐ Yes ☐ No Have you received all three doses of the HPV vaccine?

2. ☐ Yes ☐ No Have you ever had ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease
   If yes, when, how, and where were you treated? _____

3. ☐ Yes ☐ No Have you ever had herpes?
   If yes, where do you have outbreaks? _____
   If yes, how often do you have outbreaks? _____
   ☐ Yes ☐ No Have you ever had syphilis?
   If yes, how, when, and where were you treated? _____

4. ☐ Yes ☐ No Have you ever used an intrauterine device (IUD) for contraception?If
   yes, please indicate when: _____
   ☐ Yes ☐ No Did you have any problem with the IUD?
   If yes, please describe: _____

5. ☐ Yes ☐ No Have you been treated for infertility?
   If yes, please describe when and treatment received: _____
   _____

6. ☐ Yes ☐ No Do you have any other concerns related to your past health history?
   If yes, please list: _____
   _____

Family History & Genetic Screening

1. What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

2. ☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect?

   If yes, please describe: _____

3. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?

   If yes, please describe: _____

4. Please describe any special needs that have occurred in children of your family or the baby's father's family (eg, cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis):

   _____

   _____

   How is this child/person related to you? _____

5. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)?

   If yes, have either of you had genetic counseling? If ☐ Yes ☐ No

   yes, have either of you had chromosomal testing? ☐ Yes ☐ No

   Where and what were the results? _____

6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

   ☐ Yes ☐ No Eastern European Jewish (Ashkenazi) Ancestry

   If yes, have you had tay–sachs screening tests? ☐ Yes ☐ No

   If yes, have you had a canavan screening test? ☐ Yes ☐ No

   If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No

   Date: _____ /_____ /_____ Result: _____

   ☐ Yes ☐ No African American

   If yes, have you had sickle cell screening? ☐Yes ☐No

   Date: _____ /_____ /_____ Result: _____

   ☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry

   If yes, have you had screening for inherited forms of anemia such as Thalassemia? ☐ Yes ☐ No French

   ☐ Yes ☐ No Canadian or Cajun Ancestry

   If yes, have you had Tay–Sachs screening tests? ☐ Yes ☐ No

7. ☐ Yes ☐ No Have you had cystic fibrosis screening?

8. ☐ Yes ☐ No Have you had any other genetic carrier screening, such as an expanded carrier screening?

   Screening: _____ Date: _____ /_____ /_____ Result: _____

9. Please list any other concerns you have about birth defects or inherited disorders:

   _____

   _____

   _____

10. ☐ Yes ☐ No Do you want a test that will tell you about your risk to have a baby with Down syndrome?

11. ☐ Yes ☐ No Is the father 45 years or older?

Psychosocial Screening*

1. ☐ Yes ☐No Do you have any problems (eg, job, transportation) that prevent you from keeping your health care appointments?
2. ☐ Yes ☐No Do you feel unsafe where you live?
3. ☐ Yes ☐No Are you exposed to second-hand smoke? ☐Yes ☐No In the past 2 months, have you used any form of tobacco, including smoked, chewed, any type of nicotine delivery system (ENDS), or vaped?
4. ☐ Yes ☐No In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐ Yes ☐No In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐ Yes ☐No Has anyone forced you to perform any sexual act that you did not want to do?
7. On a 1–5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High
8. How many times have you moved in the past 12 months? _____
9. If you could change the timing of this pregnancy, would you want it ☐earlier ☐later ☐not at all/NA

*Modified with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

Menstrual History

Last Menstrual Period ☐ Definite ☐ Approximate (Month Known) Duration:_____Days Frequency:_____ Days Prior

☐ Unknown ☐ Normal Amount / Duration Menses:_____Date Contraception at Pregnancy ☐ Yes ☐ No

☐ Final: _____ Menarche: _____(Age Onset) Pregnancy Test ____/____/_____

Past Pregnancies

Date	GA Weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Comments / Complications

Notes