name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_

date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_ \_ occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Obstetric History Questionnaire

first day of last period:

any recent testing: 🞏 Yes 🞏 No

if yes, explain (what testing/when): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_

are you experiencing any of the following: nausea: 🞏 yes 🞏 no vomiting: 🞏 yes 🞏 no bleeding: 🞏 yes 🞏 no

pelvic pain: 🞏 yes 🞏 no

are you experiencing any other problems with current pregnancy: 🞏 yes 🞏 no (if yes, explain)

\_\_\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

preferred pharmacy (name/street/city):

preferred lab: 🞏 sutter lab 🞏 quest lab 🞏 labcorp 🞏 other:

## current medications:

are you taking prenatal vitamins: 🞏 yes 🞏 no

other medications:

|  |  |  |
| --- | --- | --- |
| medication name | dose | last taken |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## prior pregnancies:

number of pregnancies

number of miscarriages

number of tubal pregnancies (ectopic pregnancies)

number of abortions

number of living children

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| date | weeks | labor length | birth wt  (lb. /oz.) | sex  (m/f) | type of delivery  (vaginal/c-sect) | anesthesia method | hospital and doctor |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

# Aiwhc Pregnancy History Form

**medical history: (if yes, list year diagnosed)**

|  |  |  |  |
| --- | --- | --- | --- |
| * diabetes | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * hypertension | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * heart disease | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * *autoimmune disorder* | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * kidney disease/uti | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * neurologic/epilepsy | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * psychiatric | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * hepatitis/liver disease | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * varicosities/phlebotis | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * thyroid dysfunction | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * infectious disease (std’s) | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * trauma/violence | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * blood transfusion | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * tobacco use | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * alcohol use | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * street drugs | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * d (rh) sensitised | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * pulmonary (tb, asthma) | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * gyn surgery | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * breast problems | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * abnormal pap smear | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * anesthetic complications | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * infertility | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ | * uterine abnormalities | 🞏 YES 🞏 NO YEAR: \_\_\_\_\_\_\_\_\_ |
| * relevant family history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| * operations/hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| * other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ethnicity/heritage:** | | | |

|  |
| --- |
| 🞏 white 🞏 native american 🞏 japanese 🞏 samoan 🞏 cambodian  🞏 other 🞏 black 🞏 middle eastern 🞏 korean 🞏 filipino  🞏 lao 🞏 chinese 🞏 guamanian 🞏 vietnamese 🞏 hispanic/latina  🞏 indian subcontinent 🞏 hawaiian 🞏 other southeast asian |

**family status/history:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | mother | father | sister | brother | mat. gmo | mat. gfa | pat. gmo | pat. gfa |
| alive |  |  |  |  |  |  |  |  |
| deceased |  |  |  |  |  |  |  |  |

**father of the baby:**

name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ ht:\_\_\_\_\_\_ \_\_ wt: \_\_\_\_\_\_\_\_\_

any health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Aiwhc Pregnancy History Form

|  |  |
| --- | --- |
| * patient’s age>/= 35 years as of estimated date of delivery | 🞏 YES 🞏 NO |
| * thalassemia (italian, greek, mediterranean, or asian background): mcv <80 | 🞏 YES 🞏 NO |
| * neural tube defect (meningomyelocele, spina bifida, or anencephaly) | 🞏 YES 🞏 NO |
| * congenital heart defect | 🞏 YES 🞏 NO |
| * down syndrome | 🞏 YES 🞏 NO |
| * tay-sachs (e.g., jewish, cajun, french canadian) | 🞏 YES 🞏 NO |
| * canavan disease | 🞏 YES 🞏 NO |
| * sickle cell disease or trait (african) | 🞏 YES 🞏 NO |
| * hemophilia or other blood disorders | 🞏 YES 🞏 NO |
| * muscular dystrophy | 🞏 YES 🞏 NO |
| * blood clots in legs or lungs | 🞏 YES 🞏 NO |
| * cystic fibrosis | 🞏 YES 🞏 NO |
| * huntington’s chorea | 🞏 YES 🞏 NO |
| * intellectual disability/autism | 🞏 YES 🞏 NO |
| if yes, was person tested for fragile x? | 🞏 YES 🞏 NO |
| * other inherited genetic or chromosomal disorder | 🞏 YES 🞏 NO |
| * maternal metabolic disorder (e.g., type 1 diabetes, pku) | 🞏 YES 🞏 NO |
| * patient or baby’s father had a child with birth defects not listed above | 🞏 YES 🞏 NO |
| * recurrent pregnancy loss, or a stillbirth | 🞏 YES 🞏 NO |
| * medications (including supplements, vitamins, herbs or otc drugs/illict/recreational drugs /alcohol since last menstrual period) | 🞏 YES 🞏 NO |
| if yes, name / strength / dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * any other history not listed above | 🞏 YES 🞏 NO |
| if yes, list here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * live with someone with tb or exposed to tb | 🞏 YES 🞏 NO |
| * patient or partner has history of genital herpes | 🞏 YES 🞏 NO |
| * rash or viral illness since last menstrual period | 🞏 YES 🞏 NO |
| * history of std, gonorrhea, chlamydia, hpv, syphilis | 🞏 YES 🞏 NO |
| * have you ever had chicken pox | 🞏 YES 🞏 NO |
| * do you have cats in your home | 🞏 YES 🞏 NO |
| * have you or your partner been exposed to the zika virus | 🞏 YES 🞏 NO |
| * other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

# Patient Financial Responsibility Policy for Obstetric Patients

Associates in Women’s Health Care will be submitting to your insurance carrier a bill shortly after the delivery of your child. Associates in Women’s Health Care will submit a bill for “Global OB Care”. This Global Care begins with your OB Physical and concludes with your 6 week post-partum care. Included within this Global OB billing is your OB Physical, all office visits pertaining to the pregnancy and the actual delivery of your baby as well as your 6-week post-partum check-up. This type of billing is a requirement of all of the insurance carriers that we are contracted with. Services that are NOT included in the global billing are ultrasounds (whether done here in the office or elsewhere), non-stress tests, and any office visit that is **not pertaining to the pregnancy.** These will be billed **separately** to your insurance carrier.

If you have a high-deductible PPO insurance plan, our billing staff will contact you within 3 days of your OB Paperwork appointment to discuss your payment requirements to fulfill your estimated financial responsibility. Associates in Women’s Health Care’s Office Policy is that 50% of the patient’s estimated financial responsibility for the Global OB Care be paid by 15 weeks of pregnancy. **Monthly payments must continue** and the entire estimated patient financial responsibility **must be paid in full by week 24 of the pregnancy.** Our billing staff will work with you to set up this payment plan and will be happy to assist with any questions you may have regarding billings or payments.

If your insurance plan requires a co-pay with each OB visit, these co-pays **must be paid when you check-in at the front desk for your scheduled visit.** If you have a co-insurance requirement for your global OB care, the billing staff will contact you to advise you what that amount is and when you need to pay it.

***IMPORTANT*: If your insurance carrier or plan changes at any time during your pregnancy, you must notify us immediately!**

Welcome to our practice! We look forward to following you through your pregnancy and delivery and are happy to assist you at any time with any questions you may have about your financial responsibility!

I have read and agree to the above terms and conditions.

Patient Signature date

# Associates in Women’s Health Care

# 5 Medical Plaza Drive, Ste 250

# Roseville, CA 95661