



OB PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE: HOME _____ CELL _____ WORK _____
EMAIL ADDRESS (for patient portal access): _____
EMPLOYER _____ OCCUPATION _____

RACE:

<input type="radio"/> White	<input type="radio"/> Asian	<input type="radio"/> Other
<input type="radio"/> Black/African American	<input type="radio"/> Hispanic or Latino (no race info available)	<input type="radio"/> Decline to Report
<input type="radio"/> American Indian or Alaskan Native	<input type="radio"/> Native Hawaiian or Pacific Islander	

ETHNICITY:

<input type="radio"/> No, not Spanish/Hispanic/Latino	<input type="radio"/> Decline to Answer	<input type="radio"/> Unknown
<input type="radio"/> Yes/Cuban <input type="radio"/> Yes/Puerto Rican	<input type="radio"/> Yes, Mexican, American, Chicano	<input type="radio"/> Yes, Other Hispanic <input type="radio"/> (Specify) _____

PREFERRED LANGUAGE:

<input type="radio"/> English	<input type="radio"/> Spanish	<input type="radio"/> Japanese	<input type="radio"/> Chinese	<input type="radio"/> Italian	<input type="radio"/> Hindi
<input type="radio"/> Portuguese	<input type="radio"/> Russian	<input type="radio"/> French	<input type="radio"/> Guatemalan	<input type="radio"/> Tagalog	<input type="radio"/> Arabic
<input type="radio"/> Bosnian	<input type="radio"/> Vietnamese	<input type="radio"/> Laotian	<input type="radio"/> German	<input type="radio"/> Gujarati	

INSURANCE INFORMATION

****please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section****

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER _____ PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY _____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____

SECONDARY INSURANCE INFORMATION (if applicable)

****please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section****

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER _____ PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY _____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____

PATIENT NAME (please print) _____ DATE OF BIRTH _____



SPOUSE/SIGNIFICANT OTHER

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____
PHONE: HOME _____ CELL _____ WORK _____
EMPLOYER _____ OCCUPATION _____

PARENT/GUARDIAN (if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ RELATIONSHIP TO PATIENT _____

ALTERNATIVE CONTACT (other than spouse/significant other – if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ RELATIONSHIP TO PATIENT _____

PREFERRED PHARMACY

NAME _____ LOCATION _____

PREFERRED LAB

We send all lab work to LabCorp. Your insurance provider may require the use of a different lab. Please select:

<input type="radio"/> LabCorp	<input type="radio"/> Other (specify): _____
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LIVING WILL

Do you have a living will?

<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I'd like information about establishing a living will
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PATIENT SIGNATURE _____ DATE _____



OUR FINANCIAL POLICY / RELEASE AND ASSIGNMENT

Full payment is due at the time of service. We accept cash, checks, and credit cards. Our practice is committed to providing the best treatment for our clients, and our charges are reasonable and customary for our area.

I am responsible for payment regardless of the insurance company's arbitrary determination of reasonable and customary rates or decisions regarding non-covered services. I agree to pay collection fees associated with any outstanding balance on my account.

I hereby authorize The Midwife Group and Birth Center/Family Health and Birth Center, Inc. to release any of my medical records deemed necessary to process my insurance claim. I authorize payment of medical benefits to The Midwife Group/Family Health and Birth Center Inc., or its providers for services rendered to me. I fully understand that I am responsible for all charges incurred because of services rendered to me and any balance remaining after my insurance pays. I, the undersigned, a patient at this facility, hereby authorize the providers (and whomever they may designate as their assistants) to administer treatment as necessary. I hereby certify that I have read and fully understand this authorization for medical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

PATIENT SIGNATURE _____ DATE _____

OR SIGNED FOR PATIENT BY _____ RELATIONSHIP _____

Late Arrival

If a patient is more than **10 minutes late** for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day **if one is available**.

We will try to accommodate late-comers in the best manner possible but cannot compromise on the quality and timely care provided to our other patients.

- If a patient presents to the office **15 minutes late** for a scheduled appointment with our providers, the patient will be asked to reschedule their appointment.
- If you are a **New Patient** and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 10-15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

Last Minute Cancelations and Missed Appointments

We require **24-hour notice** on all cancelations. As a courtesy to our patients, we attempt to confirm all appointments. We recognize that situations arise that are out of your control; however, it is imperative that you contact our office immediately to notify us of your cancelation in a timely manner.

Appointments canceled with less than a 24-hour notice or NO SHOW to your appointment will be subject to a \$40.00 fee. ***We ask for your consideration and cooperation in scheduling your next appointment. Please understand that we are partners in your health care, and we are committed to offering you appropriate care when you need it.***

Signature

Date:



DISCLOSURE OF CONFIDENTIAL INFORMATION (select one)

<input type="radio"/> I choose to have voicemail left with minimally necessary information. In the event that I am not available, you may leave a message	<input type="radio"/> I choose to opt-out of voicemail messages.
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I authorize you to disclose information about my care and allow the following individual/s to schedule, reschedule, and cancel appointments on my behalf:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT SIGNATURE _____ DATE _____

CONFIDENTIALITY AGREEMENT FOR PARTICIPATION IN GROUP PRENATAL CARE (for pregnant patients only)

You have the right to expect what is said in class to remain private and confidential. Along with our commitment to maintain your privacy, you also have a responsibility to respect and protect each other's privacy. If you have any questions about this policy, you may ask our HIPAA compliance officer.

I have read the Privacy Notice and understand these policies.

PATIENT SIGNATURE _____ DATE _____

PRIVACY NOTICE

This privacy notice describes how your medical information may be disclosed and used by this practice. This notice also discusses your rights to access your medical information.

The HIPAA (Health Insurance Portability and Accountability) Privacy Rule allows your health information to be disclosed to carry out treatment, payment, and other healthcare operations. We must abide by the information outlined in this privacy notice. We reserve the right to update this policy as changes occur in the HIPAA Privacy Rule. HIPAA grants you the right to access and control your health information.

USES AND DISCLOSURES

Treatment: Your health information will be disclosed to provide, coordinate, and manage your healthcare. All providers in our practice may have access to your medical records. Additionally, our medical consultants and ultrasonographer may review some records to assist us with your care. Your health information may be disclosed to any other physician or healthcare provider that may become involved in your care.

Healthcare Operations: Your health information will be used to support the business activities of the practice. Examples include, but are not limited to: quality assessment, employee reviews, nursing and midwifery student training, licensing, and other business activities. Health information may be shared in our group prenatal sessions.

Payment: Your health information will be used to obtain payment for services provided by this practice. Disclosures may be given to health plans, insurance providers, and collection agencies.

Business Associates: Your health information may be shared with third party business associates. Examples include billing and legal services. We have established written contracts that contain the terms that will protect your health information with all third-party business associates. All business associates must follow HIPAA guidelines.

Disclosures Requires by Law and Workers Compensation: We are allowed to disclose your health information to follow workers compensation laws and legal proceedings. If required, you will be notified of disclosure. The protected health information of members of the armed forces may be disclosed to authorized federal officials, under certain circumstances.

Abuse or Neglect: We may disclose your protected health information to the proper authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.

Emergencies: If you are incapacitated, we may use our best judgement to disclose information that is only directly relevant to your care.

Research and Health Oversight: We are allowed to disclose your information to researchers with an institutional review board has reviewed a research proposal and established protocols to ensure your health information will be kept confidential. We are allowed to disclose your health information to a health oversight agency for activities authorized by law. Examples include audits, investigations, and inspections.

Written Authorization: Unless not required by law, your written authorization will be needed for all disclosures of your protected health information. You can revoke authorization at any time via written request. It is important to note that we are unable to undo any disclosures previously made with your authorization.

Voicemail: Employees may only leave detailed voicemail messages if the greeting appropriately identifies the patient or another person who is authorized to receive information about the patient. If there is not proper identification, only the minimum necessary information will be left. This includes the caller's name, practice name, and a contact number. Patients have the right to opt out of voicemail messages.

PATIENT RIGHTS

You have the right to be treated with respect, dignity and consideration in all your interactions and communications. You have the right to inspect and copy your protected health information. You may obtain your medical record that contains medical and billing information. As permitted by federal or state law, we may charge you a reasonable copy fee to provide a copy of your records. You may request an amendment to your protected health information. We reserve the right to deny your request. If we deny your request for amendment, you have the right to file a statement of disagreement. We may provide you with a copy of any rebuttal. Federal law prohibits you from inspecting or copying psychotherapy notes and information compiled in reasonable anticipation of, or use of, civil or criminal proceedings, or administrative actions or proceedings.

PRIVACY COMPLAINTS/ CLIENT GRIEVANCES

Should you believe that your privacy rights have been violated, and wish to file a complaint, you may contact us by calling our office at (912)629-6262 and asking to speak with our privacy officer. The director or her designee will personally respond within 10 business days to any complaint registered by a client about any aspect of Family Health and Birth Center. You may also contact our accrediting organization, The Commission for the Accreditation of Birth Centers at 240 Independence Drive, Hamburg, PA 19526, phone number 1-877-241-0262. Unresolved complaints may be directed to the Georgia Department of Community Health, Health Facilities Regulation Division, Attention: Complaints, 2 Peachtree Street NW, Atlanta, GA 30303-3142, phone: 1-800-878-6442.

I have read the Privacy Notice and understand these policies.

PATIENT SIGNATURE _____

DATE _____



HIV TESTING IN PREGNANCY (for pregnant patients only)

The HIV test is a routine screening in pregnancy. While I do have the right to refuse HIV testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to HIV testing and understand that the result will become a part of my medical record.

PATIENT SIGNATURE _____ DATE _____

DRUG TESTING IN PREGNANCY (for pregnant patients only)

Because the use of illegal drugs/substances is potentially harmful for me and my fetus, drug screening is a routine screening in pregnancy. While I do have the right to refuse drug testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to drug testing and understand that the results will become a part of my medical record.

PATIENT SIGNATURE _____ DATE _____

NO SHOW FEE

We understand that there are times when you may miss an appointment due to emergency or unexpected obligations for work or family, however, when you do not call to cancel your appointment in a timely manner, you may be preventing another patient from getting an appointment. If an appointment is not cancelled at least 24 hours in advance, you may be charged a \$40 fee. This fee will not be covered by your insurance company.

PATIENT SIGNATURE _____ DATE _____

PARTICIPATION IN EDUCATION

I hereby give my permission for the participation of students in my care. Students will always be supervised by a Certified Nurse Midwife, Nurse Practitioner, Medical Doctor, Radiologic Technologist, or Registered Diagnostic Medical Sonographer. I may refuse student involvement at any time.

PATIENT SIGNATURE _____ DATE _____

AABC PERINATAL DATA REGISTRY (for pregnant patients only)

The purpose of this data registry is to help improve and maintain quality of care of childbearing families, provide for ongoing and systematic collection of data on normal birth, and facilitate research on maternity care practices that support optimal birth. By consenting to participate in this registry I understand that all information about me and my pregnancy will be kept confidential. As required by HIPAA, no identifying information will be seen by those conducting the project except for my date of birth and zip code. Statistical data will be kept on file and may be used later by other researchers who are studying specific parts of birth center or midwifery care. I freely consent to participate, and also give permission for data about my newborn to be used.

PATIENT SIGNATURE _____ DATE _____

PRINTED PATIENT NAME _____



DISPLAY NAME AND DUE DATE ON BULLETIN BOARD CONSENT

Some parents choose to display their first name and due date (as well as baby's name, date of birth and weight after delivery) on our bulletin board. The HIPAA privacy law requires that our office have written consent to display this information at our facility. HIPAA also requires that we allow you to choose an expiration date at which time your information will be removed from display.

- I give permission to have my name, due date, baby's name, date of birth, and weight displayed on the bulletin board. It will be taken off display and provided to me at my six week postpartum visit (or destroyed)
- I do not give the birth center permission to display information about me or my baby

SIGNATURE _____ DATE _____

PHOTO DISPLAY CONSENT

Some parents choose to send us photographs of their babies to display on the bulletin board. The HIPAA privacy law requires that our office have written consent to display any photographs that you send to our facility. HIPAA also requires that we allow you to choose an expiration date at which time your photograph will be removed from display and discarded.

- I give permission to have any pictures I send to the birth center displayed on the bulletin board indefinitely
- I do not give the birth center permission to display any photos I may send
- I give permission to have any pictures I send to the birth center displayed on the bulletin board until the following date : _____

SIGNATURE _____ DATE _____

PRINT NAME _____



OB HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please complete **ENTIRE** form.

Name (Last, First, M.I.):		DOB:	
Marital status:		<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Significant other's name:		He/She is <input type="checkbox"/> present for pregnancy <input type="checkbox"/> deployed <input type="checkbox"/> incarcerated	
Is this pregnancy planned or unplanned?		Do you have supportive family and friends?	
Highest level of education:		Employment: What is your job?	
Who do you live with?			
What are your living arrangements? <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home <input type="checkbox"/> Other			
PERSONAL MEDICAL AND SURGICAL HISTORY: Please complete this portion of your health history in the <i>patient portal</i> PRIOR to your appointment. This is a very important part of your care and we want to make the most of your visit with the midwife by having the most updated and complete information. <u><i>If the patient portal is not completed, we may be required to reschedule or have you return for an additional visit to complete the appointment.</i></u>			
FAMILY HEALTH HISTORY: Your family history is very important for certain health screening as well as anticipating your health care needs. Please ensure you complete this section in the <i>patient portal</i> PRIOR to your appointment.			

OB/GYN HEALTH HISTORY			
Last Menstrual Period:			
Last pap test:		Have you ever had an abnormal Pap test?	
Age period began?		Length of periods?	#days between periods?
Any recent changes in your periods?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you sexually active?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use birth control?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you do regular self-breast exams?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Since your last period, have you had any illnesses, rash, fever or exposure to x-rays or toxic chemicals?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you born premature (<37 weeks)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently breast feeding another baby?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a UTI (urinary tract infection) within 6 months of this pregnancy		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced any of the following (check all that apply): <input type="checkbox"/> NONE			
<input type="checkbox"/> Sexual or physical abuse or assault		<input type="checkbox"/> Domestic violence	
<input type="checkbox"/> Emotional Abuse		<input type="checkbox"/> Childbirth trauma	
<input type="checkbox"/> Major accident or illness or other traumatic event			



Name: _____

Pregnancy History	Total # pregnancy: _____ # Premature births _____ #miscarriages/ abortions: _____ # term births? _____
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LAST NAME:						DOB:
Baby date of birth day/month/year	Weight	Sex	Weeks pregnant	Type of birth	Length of labor	Complications/ Comments

NUTRITION & EXERCISE

Exercise	Do you exercise? Yes <input type="checkbox"/> No <input type="checkbox"/> What type of exercise do you enjoy? _____	How often? _____
Diet	Are you on any special diet or have dietary restrictions? If so what? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you eat three meals a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a working stove?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have running hot and cold water?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you receive WIC?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you able to purchase the foods you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like to speak to someone about your diet and foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
#meals you eat in an average day?	How much water a day?	How much caffeine a day?

How often do you eat:	Never	2-3 times/month	Once/week	2-3 times/week	Once/day	2-3 times/day
Fast/restaurant food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frozen meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home-cooked meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beef	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken/Turkey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish, Type?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deli meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cookies/Cakes/Muffins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other refined grains (white bread, white rice, white pasta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables (fresh, frozen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit (Fresh, frozen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canned vegetables/fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy (milk yogurt, cheese, butter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial sweetener	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal replacement bars or shakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NAME: _____

Genetic Screening:

Comments

Are you older than 35 at the time of birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Family history of thalassemia (Italian Greek, Mediterranean or Asian)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History of Neural tube defect (meningomyelocele, spina bifida)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Congenital heart defect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Downs Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tay-sachs (Ashkenazi Jewish, Cajun, French-Canadian)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Canavan Disease (Ashkenazi Jewish)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Familial dysautonomia (Ashkenazi Jewish)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sickle cell disease or trait	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hemophilia or other blood disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Muscular dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Huntington Chorea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mental retardation or autism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other inherited genetic or chromosomal disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Maternal metabolic disorder (diabetes type 1 or PKU)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
You or baby's father had a child with birth defects not listed above	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Recurrent pregnancy loss or stillbirth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Medications including supplements, vitamins, herbs, illicit drugs, recreational drugs or alcohol or exposure to toxic chemicals or X-rays since last menstrual period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Infection history:

Comments:

Do you live with someone with TB or exposed to TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had chicken pox or had the vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had the HPV vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you or your partner have a history of herpes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had a rash or viral illness since your last period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a history of Hepatitis B or C?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a history of STDs (gonorrhea, chlamydia, HPV, HIV or syphilis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Reviewed by: _____ Date: _____