PATIENT VISIT-COMPREHENSIVE HISTORY

Name: _____ Age _____ Date: _____

What is the reason for your visit today? _____

_____

PERSONAL PAST HISTORY: (Please provide as much detail about **your** medical history as possible)

Diabetes	Yes	No
High Cholesterol (Including High Lipids/Triglycerides	Yes	No
Kidney disease	Yes	No
Urinary Infection	Yes	No
Neurologic Disease	Yes	No
Depression	Yes	No
Hepatitis	Yes	No
Thyroid disease	Yes	No
Domestic Violence	Yes	No
Asthma/TB	Yes	No
Breast Problem	Yes	No

High Blood Pressure	Yes	No
Heart Disease	Yes	No
Autoimmune Disorder (such as Lupus, Positive ANA)	Yes	No
Epilepsy/Seizures	Yes	No
Psychiatric illness	Yes	No
Liver Disease	Yes	No
Blood Clot in leg/lung	Yes	No
Trauma	Yes	No
Blood Transfusion	Yes	No
Seasonal Allergies	Yes	No
Infertility	Yes	No

Explanation: _____

_____

GYN Surgery . . . . Y N If yes, what type and when: _____

_____

_____

Other Surgery . . . . Y N If yes, what type and when: _____

_____

_____

_____ _____

Have you been vaccinated for or had the following:

Chicken Pox	Yes	No	Measles	Yes	No	Mumps	Yes	No	German Measles	Yes	No
Hepatitis B	Yes	No	Tetanus	Yes	No	Diptheria	Yes	No	Pertussis	Yes	No
Polio	Yes	No									

GYN HISTORY: What was the first day of your last normal menstrual period? _____/_____/_____

Age of 1st menses _____ yrs Have you received Gardasil or Cervarix Vaccine? Y N

How often do you get your period? Monthly Less than once a month More than once a month

Is your period heavy? Y N Do you pass clots with your period? Y N

What method of birth control do you currently use? (circle one or more) Abstinence Menopause Pills

Patch Ring Condom IUD Shot Tubes Tied Essure Vasectomy Timing Withdrawal Spermicide

Have you ever had an abnormal Pap Smear? Y N If so, when? _____ How was it treated? _____

Date of last Pap Smear? _____ Normal? Y N Date of last mammogram? _____ Normal? Y N

Date of last pelvic ultrasound (sonogram)? _____ Normal? Y N

Infection History:

Live with someone with TB	Yes	No		Gonorrhea (you or your partner)	Yes	No
Genital Herpes (you or your partner)	Yes	No		Chlamydia (you or your partner)	Yes	No
Rash or Viral Illness	Yes	No		HPV or Genital Warts (you or your partner)	Yes	No
Live with someone with Hepatitis B or C	Yes	No		Syphilis (you or your partner)	Yes	No
Any other Infectious Disease	Yes	No	Explain:			

OB HISTORY:

Total number of pregnancies in your life _____ (please include miscarriages and pregnancy terminations)

Past Pregnancies (please list **all** pregnancies):

Delivery Date	Weeks of Pregnancy	Hours in Labor	Birth Weight	Sex of Baby	Type of Delivery	Anesthesia	Place of delivery	Complications

FAMILY HISTORY:

Mother: Alive? Y N Year of mother's birth? _____

Did/Does your mother have:

Alzheimer's Disease Birth Defects Blood Clot in Leg/Lung Breast Cancer Colon Cancer

Drug or Alcohol Problems Diabetes Heart Disease Hepatitis HIV High Cholesterol High Blood Pressure

Mental Illness Osteoporosis Ovarian Cancer Stroke Tuberculosis Uterine Cancer

Father: Alive? Y N Year of father's birth? _____

Did/Does your father have:

Alzheimer's Disease Birth Defects Blood Clot in Leg/Lung Breast Cancer Colon Cancer

Drug or Alcohol Problems Diabetes Heart Disease Hepatitis HIV High Cholesterol High Blood Pressure

Mental Illness Osteoporosis Prostate Cancer Stroke Tuberculosis Uterine Cancer

Others: (Circle all that apply to your other relatives: siblings, grandparents, aunts, uncles, cousins, etc.)

Alzheimer's Disease Birth Defects Blood Clots Breast Cancer Colon Cancer Drug or Alcohol Problems

Diabetes Heart Disease Hepatitis HIV High Cholesterol High Blood Pressure Mental Illness

Osteoporosis Prostate Cancer Stroke Tuberculosis

SOCIAL HISTORY:

Do you drink alcohol? Y N If so, how many drinks per day? _____

Do you smoke cigarettes? Y N If so, how many packs per day? _____

Do you use another form of Tobacco (chewing tobacco, cigars, etc.)? Y N

Do you use any street drugs? Y N If so, what drug and how often? _____

Do you have sexual intercourse with: Men Women Both Nobody

Are you currently in a long-term mutually monogamous relationship? Y N

REVIEW OF SYSTEMS: (Please circle any of the following that you are currently experiencing)

Breast: lump or mass nipple discharge pain

Urinary: difficulty urinating blood in urine frequent urination incontinence (leaking)
awake to urinate at night pain with urination

Ear, Nose & Throat: runny nose cough hearing loss ringing in ears sore throat sores in mouth
sinus congestion

Cardiac: chest pain palpitations swelling of legs dizziness varicose veins

Respiratory: shortness of breath coughing wheezing pain with deep breathing

Eyes: diminished vision eye irritation drainage from eyes blurring of vision loss of vision

Neurologic: headache tingling/numbness seizures insomnia memory loss difficulty walking

Endocrine: excessive thirst excessive urination cold intolerance heat intolerance hot flashes hair loss

Skin: rash moles lumps dry or sensitive skin hives

Constitutional: weight gain loss of appetite fever weakness weight loss excessive fatigue

Gastrointestinal: nausea heartburn vomiting difficulty swallowing diarrhea constipation blood in stool

Skeletal: joint swelling joint pain leg cramps joint stiffness muscle pain/ache muscle weakness

Reproductive: heavy periods pain with intercourse pelvic pain pain with period
vaginal itching or burning abnormal vaginal discharge

Current Medications: Please list the name and dosage, including over the counter (such as Tylenol, Advil, Glucaosamin/Chondroitin, Etc.) and herbal products (such as Black Cohash, Gingko, Herbal Teas, Herbal Juices, etc.). (If you have a list, we will be happy to make a copy of it for our records so that you do not have to write it).

_____

_____

_____

_____

_____

Medication Allergies: ☐ None Known _____

_____

_____

Is there any information you think the doctor should have that you have not already written down?

_____

_____

_____

Answer the following section only if you are pregnant:

Genetic Screening and Teratology (including you, the baby's father, & anyone in either family)

Italian, Greek, or Asian Heritage	Yes	No		Huntington's Chorea	Yes	No
Spina Bifida, Neural Tube Defect	Yes	No		Mental Retardation	Yes	No
Born with heart problem	Yes	No		Inherited Disease	Yes	No
Down Syndrome	Yes	No		Metabolic Disorder	Yes	No
Jewish, Cajun or French Canadian	Yes	No		Birth Defect	Yes	No
Canavan Disease	Yes	No		Stillbirth or Repeated Miscarriage	Yes	No
Sickle Cell or African Heritage	Yes	No		Hemophilia (bleeding problem)	Yes	No
Cystic Fibrosis	Yes	No		Muscular Dystrophy	Yes	No

_____ _____

Patient Signature Date

Name _____ Social Security # _____ Age _____

Birth Date _____ Driver's License # _____ DL State _____

e-mail address: _____@_____

Home Phone # _____-_____-_____ Cell Phone # _____-_____-_____ Work Phone # _____-_____-_____

Marital Status [] S [] M []W [] D Religion: _____ Primary Language [] English [] Other: _____

Street Address _____ Apt # _____

City _____ State_____ Zip _____

Employer/School _____ Title _____

Street Address _____ City _____ State_____ Zip _____

Spouse _____ Age _____ Birthdate _____

Spouse Employer _____ Title _____ Phone # _____

Street Address _____ City _____ State_____ Zip _____

Referred by: _____ Primary Care Physician: _____

Person to contact in an emergency who does not live with you:

Name _____ Phone # _____ Relationship _____

Street Address _____ City _____ State_____ Zip _____

Primary Insurance Information: Is this an employer plan? Y N

Company _____ Insured's Name _____ Insured's D.O.B. _____

Insured's SS # _____ ID # _____ Group # _____

Street Address _____ City _____ State_____ Zip _____

Phone # _____-_____-_____ Your relationship to insured [] Self [] Spouse [] Child [] Other

Secondary Insurance Information: Is this an employer plan? Y N

Company _____ Insured's Name _____ Insured's D.O.B. _____

Insured's SS # _____ ID # _____ Group # _____

Street Address _____ City _____ State_____ Zip _____

Phone # _____-_____-_____ Your relationship to insured [] Self [] Spouse [] Child [] Other

Guaranty of Payment: I fully understand that I am directly responsible for payment to Westside OB/GYN Group, L.L.C. for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collecting costs including reasonable attorney's fees in the event it becomes necessary to file suit for payment. I authorize payments to be made directly to Westside OB/GYN Group, L.L.C. Authorization to Release Information I hereby authorize Westside OB/GYN Group, L.L.C. to release any information acquired in the course of my visit or treatment to my insurance company for the purpose of processing any insurance claim. Assignment of Insurance Benefits If insurance claims are filed on my behalf, I hereby authorize direct payment of any benefits to Westside OB/GYN Group, L.L.C. for any treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of this authorization to be used in place of the original. . In addition, I authorize Westside OB/GYN Group, L.L.C. to access records of my prescription medications directly from the pharmacy whenever it is deemed necessary for my care.

Signature _____ Date _____

(parent if patient is a minor)

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

(Please note: you are not required to list any name if you do not so choose)

[] I do not wish my information to be released to anyone

I, _____, authorize Westside OB/GYN Group, L.L.C. to release or discuss information related to my medical condition (including information related to my treatment plan, medication, disease or diagnosis and/or billing information) to the following named persons (this negates all prior authorization):

1. _____ 2. _____

3. _____ 4. _____

Please list phone numbers where you would like us to contact you for:

• Results – Lab, Ultrasound, X-ray, Mammography, etc.

• Reminders for or changes of appointments

1. _____ [] OK to leave detailed message

2. _____ [] OK to leave detailed message

Patient's Name: _____

DOB: _____ SS # _____

Date: _____ Signature: _____

INFORMATION ON FETAL CHROMOSOMAL SCREENING AND DIAGNOSIS

Please read all of the following information carefully. You will have the opportunity to ask questions and then you will need to make a decision and sign a consent/request form.

Babies may be affected with chromosome abnormalities, the most common being Down Syndrome, a disorder that leads to mental retardation and other birth defects. Generally, risk of chromosome abnormalities becomes greater as the age of the expectant parents Increases. For women 35 years of age or more at the time of delivery, the standard recommendation has long been a genetic amniocentesis (the removal of amniotic fluid for analysis) which is a diagnostic test. Most expectant parents choose to have a non-invasive screening test before deciding to have an amniocentesis.

It is important to understand that a screening test is limited; a result that shows increased risk does not mean that the baby actually has an abnormality; a result that is within the normal range (low-risk) does not necessarily mean that there are no abnormalities present. Mothers whose test results show increased risk will be offered further evaluation by invasive testing with amniocentesis, a diagnostic test that identifies most known chromosome abnormalities. The options for SCREENING include:

-Cell-Free Fetal DNA testing: This is a blood test done on the mother and is a highly accurate, non-invasive Down syndrome screening blood test. It is typically done at around 13 weeks of pregnancy.

Cell-Free Fetal DNA also tests for two other genetic conditions, trisomy 18 (Edward syndrome) and trisomy 13 (Patau syndrome). In addition, with Cell-Free Fetal DNA testing you have the option to evaluate X and Y sex chromosomes and learn the sex of your baby.

Currently, most insurance companies do not cover cell-free fetal DNA testing for low-risk patients but the Harmony Prenatal Testing Laboratory has agreed to perform the test on our low risk patients for $199.

-Integrated Screen: This screening test combines testing performed between 11 weeks and 13 weeks + 6 days. The first part includes a sonogram to measure the amount of fluid accumulation at the back of the baby's neck (Nuchal Translucency) and a blood sample that is tested for special markers. with additional information obtained from another blood test, the alpha-fetoprotein 4 (AFP4), taken at approximately 16 -18 weeks. The result of this screen will not be available until the second trimester of pregnancy, as the results of the second blood sample are needed to complete the analysis. Of all the currently available screening tests, this screen has the highest detection rates for Down syndrome and Trisomy 18. Integrated Screen also reports the risk of Open Neural Tube Defect (ONTD).

-Multiple Marker Screen: The multiple marker screen is the standard screening test offered at the present. The Multiple Marker Screen (AFP4), a single blood test obtained at approximately 16 - 18 weeks, measures levels of alpha-fetoprotein (AFP) combined with levels of certain other proteins and hormones from the pregnancy. The quadruple marker test (AFP4), the best second trimester prenatal serum screening test currently available, measures levels of a three additional markers: unconjugated estriol (uE3), human chorionic gonadotropin (hCG), and inhibin A. When tests of these markers are added to the AFP test, the combination gives more information about the risk of having a baby with Down syndrome than the AFP test alone. No testing is performed in the first trimester of pregnancy. The results of this screen are not available until the second trimester of pregnancy. Detection rates for Down syndrome and trisomy 18 are lower than with the Integrated Screen, but detection rates for ONTD are the same.

-No screening: You may choose not to undergo any screening test. Some patients who feel that they would not intervene if the baby should have a problem may prefer this option.

The screening tests offer the following performance:

Screening tests for low-risk pregnancies	Down Syndrome Detection Rate	False Positive Rate	Trisomy 18 Detection Rate	Risk to the baby
Integrated Screen	**92%**	**5%**	**90%**	**0%**
Multiple Marker Screen	**81%**	**5%**	**80%**	**0%**
No Screen	**0%**	**0%**	**0%**	**0%**
Diagnostic tests for High-Risk Pregnancies	Down Syndrome Detection Rate	False Positive Rate	Trisomy 18 Detection Rate	Risk to the baby
Cell-Free Fetal DNA	**99.9%**	**<1%**	**99.9%**	**0%**
Amniocentesis	**100%**	**Near 0%**	**100%**	**0.5%**
No testing	**0%**	**0%**	**0%**	**0%**

What if your test shows an increased risk? If your screening test shows an increased risk, it does not mean that a problem has been diagnosed. It only means that your baby should be further evaluated. In that case, you will be offered additional tests which can determine whether the baby has a disorder or if there are other explanations for the test result. If your screening test shows results in the "normal range", it does not guarantee that your baby is normal. It means that the risk of a problem is low. Problems or abnormalities may be present or may develop in the baby.

If you will be 35 years-old or more on your due date, or have had a previous baby with a birth defect or inheritable disease you will be referred for genetic counseling and consultation with a maternal-fetal medicine specialist. The specialist will review your options for testing with you and you will make your decision at their office.

If you will be less than 35 years-old on your due date, and have not had a previous baby with a chromosome anomaly or Open Neural Tube Defect (ONTD) our recommendation is either Harmony or Integrated Screen. However, any patient who wishes to consider other testing alternatives can be referred to the maternal-fetal medicine specialist for counseling and evaluation.

Please read all of the above information carefully. You will have the opportunity to ask questions and then you will need to make a decision and sign the consent/request below.

CONSENT

I have reviewed the information titled “INFORMATION ON FETAL CHROMOSOMAL SCREENING AND DIAGNOSIS.” All my questions have been answered to my satisfaction. I understand that there are benefits and limitations for any test, including false positives and false negative results. I understand that this test is voluntary and I may decline testing at any point.

My healthcare provider may release my ultrasound, amniocentesis, chorionic villus sampling, and pregnancy outcome information to the laboratory.

I understand that my insurance company may not cover this service and I agree to provide payment.

YOU MUST CHOOSE ONE (<u>AND ONLY ONE</u>) OF THE FOLLOWING:

I accept:

0 Referral to maternal-fetal medicine for evaluation and possible testing (for patients over 35 or other risks)

0 Cell-free fetal DNA testing with Harmony (for low-risk patients) and I agree to pay if the test is not covered

0 Integrated Screen (sonogram for Nuchal Translucency and blood testing at

11 weeks -13 weeks and 6 days plus another blood sample at approximately 16 -18 weeks)

0 Multiple Marker Screen (blood sample at approximately 16 - 18 weeks)

0 No screen at all

_____ _____

Patient Signature Date

_____

Witness

FLORIDA BIRTH-RELATED NEUROLOGIC INJURY COMPENSATION ASSOCIATION

RECEIPT OF NOTICE TO OBSTETRIC PATIENT

I have been furnished information in the form of a Brochure prepared by the Florida Birth-Related Neurologic Injury Compensation Association (NICA), pursuant to Section 766.316, Florida Statutes, by Westside OB/GYN Group, L.L.C., the office of Dr. Anthony Hood and Dr. Ghea Adeboyejo, and have been advised that Dr. Hood and Dr. Adeboyejo are participating physicians in that program, wherein certain limited compensation is available in the event certain types of qualifying neurological injuries may occur during labor, delivery or resuscitation in a hospital. For specifics on the program, I understand that I can contact the Florida Birth-Related Neurologic Injury Compensation Association, Post Office Box 14567, Tallahassee, Florida, 32317-4567, (800) 398-2129.

In addition, I have been informed that Dr. Robert Bass, Dr. Marion Colas-Lacombe, Dr. Jaime Mercado, Dr. Maria Suescum-Diaz and Dr. Stratton Sterghos, Jr. provide coverage for Dr. Anthony Hood and Dr. Ghea Adeboyejo and are also participating physicians in that program described above.

I specifically acknowledge that I have received a copy of the Brochure prepared by NICA.

Dated this _____ day of _____, 20_____.

Signature of Patient: _____

Printed Name of Patient: _____

Social Security Number of Patient: _____

Attest:
Witness: _____ Date: _____

WESTSIDE OB/GYN GROUP, L.L.C.

CONSENT FOR HIV ANTIBODY TESTING

HIV testing is recommended to all pregnant women by law in the State of Florida both at the beginning of pregnancy and again in the third trimester.

I hereby consent to have my blood tested for the antibody to the Human Immunodeficiency Virus (HIV).

1. Explanation of the Test: The purpose of the test, its potential uses, the limitations and the meaning of its results has been explained to me. I understand that if the test results indicate that my blood contains antibody to HIV, it means that I have been exposed to the HIV virus, which is believed to cause AIDS (Acquired Immune Deficiency Syndrome) and/or ARC (AIDS Related Complex).
2. Education: Information regarding measures for the prevention of exposure to, and transmission of HIV virus has been made available to me.
3. Test Results: I understand that my physician or his staff will report the result to me. At that time, I will be offered the opportunity to receive counseling about the meaning of the results and other matters.
4. Confidentiality: I understand the test results are confidential and will not be disclosed without my consent or unless permitted by law.
5. Consent to Release: I hereby consent to the release of the results to Plantation General Hospital for my delivery if I am pregnant. I understand that the hospital will comply strictly with the law regarding access by hospital employees to the results.

My signature confirms that I have read this consent form; that I have asked all the questions I have about the test, that my questions have been answered to my satisfaction, and that I voluntarily agree to be tested for the HIV antibody.

_____ _____

Patient Signature Date

_____

Witness

WESTSIDE OB/GYN GROUP, L.L.C.

OBSTETRICAL LABORATORY CONSENTS

In keeping with our desire to offer our prenatal patients the finest care, we offer testing for several diseases that would not always be considered part of routine prenatal laboratory studies. All of these diseases can be transmitted from you to your baby during pregnancy or birth and that is the reason for you to consider being tested.

1. Toxoplasmosis is a disease carried by cats and transmitted through their excrement. The general recommendation is to avoid the cat litter and not allow yourself to be scratched by the cat. Many cat owners have been exposed and are immune to the disease. Although we would still recommend that you take these steps to avoid exposure, there is a blood test to determine if you have been exposed in the past.

    - ☐ I do not have any exposure to cats and do not need testing
    - ☐ I decline testing for Toxoplasmosis
    - ☐ I accept testing for Toxoplasmosis

2. Varicella-Zoster (Chicken Pox & Shingles) is a common childhood illness that most adults cannot get again. It is common for adults to be exposed to the virus either from friends or relatives with Chicken Pox or Shingles. When pregnant women are exposed, it raises concerns about them getting infected, and many of us cannot be 100% certain that we had Chicken Pox as a child. The blood test can tell us for certain if you are immune to the virus.

    - ☐ I know that I have had Chicken Pox or Shingles in the past and do not need testing
    - ☐ I decline testing for Varicella-Zoster
    - ☐ I accept testing for Varicella-Zoster

My signature confirms that I have read this consent form; that I have asked all the questions I have about the tests, that my questions have been answered to my satisfaction, and that I voluntarily agree to be tested.

_____ _____

Patient Signature Date

_____

Witness

WESTSIDE OB/GYN GROUP, L.L.C.

CONSENT FOR OBSTETRICAL CARE

I have begun prenatal care with Dr. Anthony Hood and/or Dr. Ghea Adeboyejo. I consent to laboratory testing for exposure to communicable diseases, current diseases or infections, substance abuse and to ultrasound testing. I understand that some of these tests are required by law or by other regulatory organizations and that if my insurance does not cover them I will receive a bill from the laboratory.

I have been informed that Dr. Hood and Dr. Adeboyejo cover for each other and that they have an agreement for coverage with other physicians, including Robert Bass, M.D., Marion Colas-Lacombe, M.D., Jaime Mercado, M.D., Maria Suescum-Diaz, M.D. and Stratton Sterghos, Jr. M.D.

I affirm that I have received no promises or guarantees regarding which physician will attend my delivery.

X_____ _____

Patient Signature Date

_____

Witness