My OB/GYN
"Women Specialists For Women"

BOARD CERTIFIED OBSTETRICS & GYNECOLOGY

Helen Salsbury, M.D, FACOG
Selena Hodgers, ARNP – BC

NEW PREGNANCY HISTORY

Date of Appointment: _____

Name: _____ **Date of Birth:** _____

MENSTRUAL HISTORY

When was the first day of your last period? _____ ☐ Unknown ☐ Approximate Date ☐ Definate Date

Previous menstrual period date _____ Menses Frequency, every _____ days Menses typically heavy? ☐ Y ☐ N

Date of Last Pap _____ On Birth Control pill at conception? ☐ Y ☐ N Age menses started _____

MEDICAL HISTORY (✔) all positive

	Diabetes			Neurologic / Epilepsy	
	High Blood Pressure			Pulmonary (TB / Asthma)	
	Heart Disease			History IUD use	
	Autoimmune Disorder			Infertility	
	Kidney Disease			Hepatitis / Liver Disease	
	Urinary Tract Infections			History Blood Transfusion	
	Thyroid Dysfunction			Anesthetic Complications	
	Breast Disease			Psychiatric	
	Cancer			Variscosities / Phlebitis	
	Uterine Anomolies			D (RH Sensitized)	
	History Abnormal Pap			Depression/Post Partum Depression	

Relevant Family History

Operations / Hospitalizations (year and reason)

 # Miscarriages _____ at _____ weeks, with or without D&C, complications _____

 # Abortions _____ at _____ weeks, complications _____

Infection History (✓) all positive

☐ Hepatitis B Immunized ☐ Live with someone with / exposed to TB ☐ History STI

☐ Self or Partner with genital herpes ☐ Rash or viral illness since last menses ☐ Other _____

	Pre-Pregnancy Amt/Day	Pregnancy Amt/Day	#Yrs Used	Notes
☐ Tobacco				
☐ Alcohol				
☐ Drugs				

GENETICS SCREENING - Include patient, baby's father, or anyone in either family (✓) all positive

	Age > 36 by estimated date of delivery		Huntinton's Chorea
	Recurrent pregnancy loss or still birth		Maternal Metabolic Disorder
	Cystic Fibrosis		Neural Tube Defect
	Congenital Heart Defect		Thalassemia
	Down Syndrome		Origin of Italian, Greek, Mediterranean or Asian
	Tay-Sachs		Other origin - French-Canadian, Jewish, African
	Canavan Disease		Other Inherited Genetic or Chromosomal Disorder
	Sickle Cell Trait or Disease		Mental Retardation / Autism
	Hemophillia or other Blood Disease		If Yes, was person tested for Fragile X?
	Muscular Dystrophy		Either parent had a child with Birth Defects not listed above

Please answer the following questions:

1) In the past year, or since you've been pregnant, have you been hit, slapped, kicked or physically hurt by someone? Y N
2) Are you in a relationship with a person who threatens or physically hurts you? Y N
3) Has anyone forced you to have sexual activities that made you feel uncomfortable? Y N

PATIENT SIGNATURE _____ Form Complete Date _____ PROVIDER SIGNATURE _____ DATE _____

My Ob/Gyn, LLC 601 NW 179th Ave. #102 Pembroke Pines, FL 33029 **Phone:** (954) 436-2867 (954-4-DOCTOR) **Fax:** (954) 442-5167

My OB/GYN
"Women Specialists For Women"

BOARD CERTIFIED OBSTETRICS & GYNECOLOGY

Helen Salsbury, M.D, FACOG
Selena Hodgers, ARNP – BC

Name: _____ **Date of Birth:** _____

NICA PARTICIPATION NOTICE for Helen Salsbury, MD

NOTICE TO OBSTETRIC PATIENTS

(See Section 766.316, Florida Statutes)

I have been furnished information by HELEN SALSBURY, M.D., prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), and have been advised that Helen Salsbury, MD is a participating physician in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, PO Box 14567 Tallahassee, Florida 32317-4567. 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATED this _____ day of _____, 201__

_____
Signature of Patient

Attest: _____
Printed Name of Patient)

_____
Nurse or Physician

_____
Date

This form is informational only, and each person, participating physician or hospital should contact their own attorney to ensure compliance with Section 766.316, Florida Statutes

My OB/GYN
"Women Specialists For Women"

BOARD CERTIFIED OBSTETRICS & GYNECOLOGY

Helen Salsbury, M.D, FACOG
Selena Hodgers, ARNP – BC

ROUTINE OBSTECTRIC LABS

Name: _____ **Date of Birth:** _____

The following chart lists the typical laboratory tests taken at My ObGyn, LLC for pregnant patients. This list is not all inclusive as some patients may require more testing due to certain medical conditions. Some tests only need to be performed once-in-a-lifetime. These tests are the cystic fibrosis, rubella, hemoglobin evaluation (includes sickle cell) and blood type. If you had any of these tests done with a previous provider, you will need to obtain these records and give to us if you do not want them repeated. The cystic fibrosis is the most expensive one. Please advise our medical assistant of your intentions before she draws your blood. Some insurances may apply the cost of these tests to your deductible. If this is true for your insurance, then you will receive a bill from the laboratory for payment.

	First Visit / 6-10 wks	24-28 wks	32-34 wks
General Testing			
CBC *Check for anemia and/or detect low platelet count*	X	X	X
ABO / Rh *Check for potential incompatibility in blood type between mother and fetus*	X		
Antibody *Rh factor antibodies (repeated at 28 wks if RhoGam is needed)*	X	X	
Pap with Chlamydia / Gonorrhea *Screen for cervical cancer and some STDs*	X		
Infectious Diseases			
Rubella (German Measles) *Check for immunity to the virus, which can cause birth defects*	X		
Syphilis (also Chlamydia & Gonorrhea, if no pap was taken) *Check for STD infections, which can cause miscarriage / infect the baby during delivery*	X		X
Hepatitis B *Check for STD infections that can infect the baby during delivery*	X		X
Hepatitis C *Check for STD infections that can infect the baby during delivery*	X		
HIV *So steps can be taken to reduce likelihood of transmission to the baby*	X		X
HSV I & II *Check for STD infections that can infect the baby during delivery*	X		
Toxoplasma *Check for infection with toxoplasmosis that can cause birth defects*	X		
Group B streptococcus *Detect infection, which can harm the baby during birth & infect the mother's uterus, urinary tract, & incisions made during a cesarean section*			X
Inherited Diseases			
Cystic Fibrosis (CF) *Check carrier status for CF*	X		
Hemoglobinopathy Eval *Check carrier status for certain abnormal hemoglobin disorders to determine risk to the baby and possible treatment for mother*	X		
Tay-Sachs *Check carrier status for certain genetic diseases to determine risk of having a baby with such a disease. Only performed if criteria met*	X		
Mother's Health			
Thyroid Stimulating Hormone (TSH) *As a screen or in women with known thyroid conditions, to adjust medication if necessary*	X		
Blood Glucose *Check for gestational diabetes - early screening only if BMI > 30*	X	X	

I am aware these are the recommended laboratory tests for pregnancy and am also aware if my insurance applies these labs to my deductible, I will be billed by the laboratory for payment.

Patient Signature _____ Date _____