CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	ENDOMETRIAL (*Uterine*) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON/RECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

If Yes, Who? _____ What gene(s)? _____ What was the result? _____

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	o **2 or more**: breast / ovarian / prostate / pancreatic cancer o **2 or more**: colon/rectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) o **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	o Breast cancer o Colon/rectal cancer o Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	o Ovarian cancer (Peritoneal/Fallopian tube) o Breast: Male breast cancer or Triple negative breast cancer^ ^(ER-, PR-, HER2- Pathology) o Ashkenazi Jewish ancestry with an HBOC-associated cancer¶ o Colon/rectal cancer with abnormal MSI/IHC, or MSI high associated histology†† o Endometrial cancer with abnormal MSI/IHC o 10 or more colon/rectal polyps*

¶ HBOC-Associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer (Gleason Score ≥ 7)

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

Office Use Only:

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If YES, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update ☐ Other:_____

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

TRINITY WOMEN'S HEALTH

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

PATIENT NAME:_____ DOB: _____
LAST FIRST

PATIENT ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____ HOME #: _____

CELL #:_____ SSN# (NEED FOR BILLING):_____HOSPITAL:_____

RESPONSIBLE PARTY (IF MINOR):_____ RELATIONSHIP:_____

EMPLOYER: _____ CONTACT PERSON:_____

EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____ WORK #: _____

EMERGENCY CONTACT: _____ RELATIONSHIP:_____ PHONE#:_____

PRIMARY CARE DOCTOR: _____EMAIL ADDRESS: _____

SPOUSE INFORMATION

SPOUSE'S NAME:_____ DOB: _____
LAST FIRST

SPOUSE'S SSN#:_____ CELL #:_____

INSURANCE INFORMATION

SUBSCRIBER NAME:_____ SUBSCRIBER DOB:_____
LAST FIRST

NAME OF PRIMARY INSURANCE:_____

SUBSCRIBER ID#:_____ SUBSCRIBER GROUP#:_____

NAME OF SECONDARY INSURANCE:_____

SUBSCRIBER ID#:_____ SUBSCRIBER GROUP#:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to the physicians of Trinity Women's Health (Drs Calinisan, Kim and/or Safie) for services rendered by them in person or under their supervision. I understand that I am **financially responsible for any balance not covered by my insurance.**

Patient Name /guardian (please print)_____
Patient Signature_____ Date:_____

PATIENT INTAKE

PATIENT NAME: _____ DOB: _____
LAST FIRST

MARITAL STATUS: SINGLE/ MARRIED/ DIVORCED/ WIDOWED OCCUPATION: _____

PAST MEDICAL & FAMILY HISTORY	PLEASE MARK (X) IF YOU (SELF) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS					
	SELF	FAM	OTHER/COMMENTS		SELF	FAM
RHEUMATIC HEART				ANEMIA		
HIGH BLOOD PRESSURE				BLOOD CLOTS (DVT)		
HIGH CHOLESTEROL				DIABETES		
CONGESTIVE HEART				THYROID DISEASE		
ASTHMA				EPILEPSY		
COPD				ALZHEIMERS		
HEPATITIS				OSTEOPOROSIS		
GERD				ANXIETY/DEPRESSION		

OBSTETRIC HISTORY	#TOTAL PREGNANY		# TERM DELIVERY		#PRETERM DELIVERY		#ABORTION/ MISCARRIAGE		#LIVING CHILDREN	
DATE OF BIRTH	SEX		DELIVERY TYPE				REMARKS			

GYNECOLOGIC HISTORY	AGE AT FIRST PERIOD		AGE AT LAST PERIOD	
	PERIOD INTERVAL (1ST DAY TO 1ST DAY)		DURATION OF BLEEDING	
PAP TEST	DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL		MAMMOGRAM	DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL
SEXUALLY TRANSMITTED DISEASES	☐ HERPES ☐ SYPHILIS ☐ CHLAMYDIA ☐ GONORRHEA ☐ HIV/AIDS			
CONTRACEPTIVE HISTORY	CURRENT CONTRACEPTIVE			
SOCIAL HISTORY	SMOKING CIG/ DAY		# YEARS	ALCOHOL DRINKS/ WK
	DO YOU FEEL SAFE AT HOME ☐ YES ☐ NO		HISTORY OF ABUSE ☐ YES ☐ NO	

MEDICATIONS	DOSE	ALLERGIES TO MEDICATION	REACTION

SURGERY	DATE	SURGERY	DATE

REVIEW OF SYSTEMS	PLEASE MARK (X) ALL THAT APPLY				
	YES	NO		YES	NO
GENERAL			**CARDIOVASCULAR**		
WEAKNESS			CHEST PAIN DURING EXERTION		
UNEXPLAINED WEIGHT LOSS			DECREASED EXERCISE TOLERANCE		
PERSISTENT FEVER			SWELLING OF HANDS OR LEGS		
SKIN			PALPITATIONS		
JAUNDICE			**RESPIRATORY**		
HIVES, ECZEMA OR RASH			CHRONIC COUGH		
FREQUENT BOILS OR INFECTION			ASTHMA OR WHEEZING		
ABNORMAL PIGMENTATION			BLOOD IN SPUTUM		
EASY TO BRUISE			**GASTROINTESTINAL**		
NEUROLOGIC			HEARTBURN OR INDIGESTION		
CONVULSIONS			NAUSEA OR VOMITING		
MEMORY LOSS			DIARRHEA		
HEADACHES			CONSTIPATION		
POOR COORDINATION			BLOOD IN STOOL		
EYES/EARS/NOSE/THROAT			ABDOMINAL PAIN OR CRAMPS		
DOUBLE VISION OR BLURRY VISION			EARLY SATIETY		
FLOATERS			LOSS OF APPETITE		
LOSS OF HEARING			**REPRODUCTIVE**		
RINGING IN EARS			IRREGULAR MENSTRUATION		
LOSS OF SMELL			LOSS OF MENSTRUATION		
BREAST			HEAVY BLEEDING		
LUMPS			PAIN WITH INTERCOURSE		
DISCHARGE			LOSS OF LIBIDO		
TENDERNESS			SPOTTING		
ENDOCRINE			**UROLOGIC**		
EXCESS THIRST			FREQUENT OR PAINFUL URINATION		
EXCESS URINATION			BLOOD IN URINE		
HEAT OR COLD INTOLERANCE			LOSS OF URINE CONTROL		
PSYCHOLOGIC			MUSCULOSKELETAL		
FEELINGS OF GUILT			MUSCLE CRAMPS		
THOUGHTS OF HURTING SELF			PAINFUL JOINTS		
THOUGHTS OF HURTING OTHERS			SWOLLEN JOINTS		

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

REVIEWED BY MD:_____ DATE:_____

TRINITY WOMEN'S HEALTH OFFICE POLICIES

Your appointment will be rescheduled if you arrive more than **10** minutes late to your scheduled appointment time for established patients. New patients must be here **30** minutes prior to appointment.

Any voicemails left will be checked throughout the same business day

There is a 72 hour turn around for all **prescription refills**. If you need a prescription refill have your pharmacist fax a refill request to our fax number (951) 677-8080 and we will take care of accordingly.

There will be a $30.00 ***CASH*** fee on all personal paperwork completed by our physicians (DMV forms, EDD forms, FMLA forms, etc…)

There is a **$50.00 fee for any missed appointments not cancelled 24 hours in advance**. Please contact us as soon as possible to cancel your appointment.

PHARMACY LISTINGS

To facilitate your prescription orders and refills, we ask that you fill out 2 pharmacy locations that you frequently use so that we may fax prescriptions in and expedited manner. **If there are any changes to your current pharmacy location information, please notify us immediately so that there is no delay in processing your prescription requests.**

Pharmacy Choice # 1:

Name of Pharmacy **Address** **Phone number**

Pharmacy Choice # 2:

Name of Pharmacy **Address** **Phone number**

PATIENT CONSENTS

PLEASE INITIAL SPACES BELOW

- I authorize the release of any Medical Information to process claims. _____
- I authorize the release of payment for Medical Benefits to Trinity Women's Health. _____
- I consent to and authorize the performance of all treatments, surgery, and medical health services by the staff of Trinity Women's Health which they deem advisable. I certify that to the best of my knowledge, all statements contained hereon are true. I understand I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. _____
- I agree to pay legal interest, collection expense, and attorney's fees incurred to collect any amount I may owe. I also authorize Trinity Women's Health to release information requested by my insurance company and/or its representatives._____
- I authorize Trinity Women's Health to photograph me and/or my medical condition for medical records._____
- I acknowledge the HIPAA (privacy practices notice) is available to print online or available on request. _____
- **I give permission to this office to release medical and billing information on my behalf, to the following person(s).**

Name: _____ Relationship: _____

Phone #: _____ Date of Birth: _____

PATIENT NAME /GUARDIAN (PLEASE PRINT)_____

PATIENT SIGNATURE_____ DATE:_____

PRIVATE POLICY STATEMENT

PURPOSE: The following policy is adopted to ensure that Trinity Women's Health complies fully with all federal and state privacy protection laws including HIPAA and California law. Violations of these polices will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution

NOTICE OF PRIVACY PRACTICE: It is the policy of Trinity Women's Health that a notice of privacy practices must be published, that a copy of this notice provided to patients at first encounter, and that all uses and disclosures of health information be done in accord with this policy. It is also the policy of the medical practice to post the most current privacy practices in the waiting room and to have copies available for distribution at our reception area.

ASSIGNING PRIVACY AND SECURITY RESPONSIBILITIES: It is the policy of Trinity Women's Health that specific individuals under our employment are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Act's requirements. It is further the policy that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum, it is the policy of the medical practice that there will be one individual designated as the Privacy Official.

DECEASED INDIVIDUALS: It is the policy of Trinity Women's Health to extend privacy protections to information regarding deceased individuals

MIMINUM NECESSARY USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: It is the policy of Trinity Women's Health that for all routine and recurring uses and disclosures of protected health information except for disclosures made for treatment purposes, or as authorized by patient or as required by law for HIPAA compliance, that such uses and disclosures be limited to the minimum amount of information needed to accomplish the purpose or use of disclosure. It is further policy that non-routine uses and disclosures be handled pursuant to established criteria. All requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

MATERIAL CHANGE: It is the policy of Trinity Women's Health that the term "material change" refers to any change in our HIPAA compliance activities

SANCTIONS: It is the policy of Trinity Women's Health that sanctions will be in effect for any member of our staff who intentionally or unintentionally violates any of these policies or procedures related to fulfillment of these policies. Such sanctions will be kept as a permanent record on the individual's personnel file.

RETENTION OF RECORDS: It is the policy or Trinity Women's Health that the HIPAA Privacy Act records retention requirement of six years will be adhered to. All records designated by HIPAA will be maintained in a manner that allows for access within a reasonable amount of time. This records retention time may be extended at this medical practice's discretion to meet with other governmental regulations or requirements imposed by professional liability carriers.

COOPERATION WITH PRIVACY OVERSIGHT AUTHORITIES: It is the policy of Trinity Women's Health that oversight agencies such as the Office of Civil right of the Department of Health and Human Services be given full cooperation in their efforts to ensure protection of health information within the organization. All personnel must fully cooperate with privacy compliance reviews and investigations.

Please read the following financial policies of this office:

NOTE: YOU WILL RECEIVE A SEPARATE BILL FROM THE LABORATORY FOR ANY LABORATORY SERVICES ORDERED (I.E., PAP SMEAR, URINALYSIS, BIOPSIES, CULTURES, BLOOD WORK, ETC.). THESE CHARGES ARE NOT INCLUDED IN OUR BILL. IF YOUR INSURANCE COMPANY IS CONTRACTED WITH A SPECIFIC LABORATORY FOR PAP SMEARS, BLOOD WORK, ETC., YOU MUST NOTIFY US AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR INFORMING THE NURSE BEFORE THE END OF YOUR APPOINTMENT.

PRIVATE INSURANCE: As a courtesy, we will bill your insurance company. We will, however, collect all percentages and/or deductibles at the time of your visit. If your insurance company requires their insurance claim form be utilized, rather than the universal HCFA 1500, it will be the patient's responsibility for providing the form prior to their office visit. If such a form is unavailable, then we will collect all charges and then you will be responsible for billing your insurance company.

SURGERY: The office will bill for all surgery charges. Please assign authorization of payment directly to the physician. Prior to your surgery, please make arrangements for payment of any deductibles and/or co-payments. If you are not covered by insurance, payment in full will be expected on the day of your pre-operative appointment. Please be aware that there may be an assistant fee, anesthesiologist fee, laboratory fee, and radiologist fee, etc.

PREFERRED PROVIDER ORGANIZATIONS (PPO or HMO): If you are covered by an insurance company that we are contracted with, please present your membership card at the front desk. We will bill your insurance company. Any co-payment will be expected at the time of your visit. Please be aware that a prior authorization may be necessary for your visit and must be obtained prior to your visit. Prior authorization is a requirement of many HMO's and their procedures and policies MUST be followed.

SECONDARY INSURANCE: Our office will bill your secondary insurance as long as the secondary allowable is greater than the primary allowable. Our office will bill your secondary insurance as a courtesy to you one time. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. At your request, we will assist you with any information you may need to bill your secondary again.

CASH: If you do not have insurance, you will be expected to make payment at the time of service. Please stop at the front desk after each Gynecological or Obstetrical visit.

ALL OBSTETRICAL PATIENTS: An account will be established on your first visit. If you have pregnancy health insurance coverage it will not be billed until you have delivered. However, any additional fees not included in your obstetrical care, such as ultrasounds, are due and payable at the time of service. You will also be responsible for all co-payments and deductibles to be paid in full by your 24th week of pregnancy. Payment arrangements should be arranged on your first visit. If you are a member of a PPO or HMO, your co-payments will be expected at each visit, if applicable. An obstetrical contract will be generated and mailed to you by our biller Susan Ford (951) 694-6102
If you have any questions, please feel free to stop at the front desk. We are here to help you in any way possible.

I have read the above information and understand my financial obligation to Trinity Women's Health

_____ _____

Patient Signature Date

Screening SMA and Cystic Fibrosis

Everyone has a risk to have a baby with problems. There are a few common disorders that can occur even without a family history and can be tested for today. You can have one simple blood test before the baby is born to determine if you carry the gene (DNA change) that causes the disorders shown below.

What is a carrier?
A carrier is a person who has a gene that increases the risk to have children with a genetic disease. People do not know if they are carriers until they have a blood test or an affected child. Some disorders occur only if both parents are carriers and other disorders only occur when the mother is a carrier.

What is carrier screening?
Carrier screening involves a blood test from one or both parents to determine if they carry a specific gene that increases the risk that their baby is affected. If you turn out to be at risk, prenatal testing such as amniocentesis or choronic villus sampling (CVS) is available to determine if your unborn baby is affected. All testing is optional and you can choose which disorder(s) to be tested. **CHECK WITH YOUR INSURANCE TO SEE WHAT YOU WILL BE RESPOSIBLE FOR.**

Disease	Cystic Fibrosis (CF)	Fragile X Syndrome	Spinal Muscular Atrophy (SMA)
Symptoms of Disease	*Most common inherited disease in North America.* A chronic disorder that primarily involves the respiratory, digestive and reproductive systems. Symptoms include pneumonia, diarrhea, poor growth and infertility. Some people are only mildly affected, but individuals with severe disease may die in childhood. With treatments today, people with CF can live into their 20's and 30's. CF does not affect intelligence.	*The most common inherited cause of mental retardation.* Fragile X syndrome is a disorder that causes mental retardation, autism, and hyperactivity. It affects primarily boys. Women who are carriers are at risk to have a child with mental retardation.	*Most common cause of inherited infant death.* SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling their head or neck, and crawling or walking. The most common form of SMA affects infant in the first months of life and can cause death between 2-4 years of age. Less commonly the disease starts later and people can survive into adulthood. SMA does not affect intelligence. There is no cure or treatment.
Inheritance	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with cystic fibrosis.	If a mother is a carrier, there is up to a 50% chance to have a child affected with fragile X syndrome	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with SMA
Population Incidence	1 in 2500 Caucasians 1 in 8400 Hispanics 1 in 16,900 African Americans 1 in 32,000 Asians Americans	Approximately 1 in 4000 males Occurs in all ethnic backgrounds	1 in 10,000 Occurs in all ethnic backgrounds.
Are you interested in testing? (please circle one)	YES NO	YES NO	YES NO

_____ _____

Patient Signature Date

OBSTETRIC QUESTIONNAIRE

DATE _____

NAME_____ ETHNICITY: American Indian or Alaska Native White Asian
(circle all that applies) Black or African American Native Hawaiian or Pacific Islander

Date of Birth_____ AGE _____ Hospital of Delivery _____

Please list all pregnancies, including miscarriages, abortions and ectopic pregnancies. Please include full birthdate.

TOTAL PREGNANCY (including this pregnancy)	FULL TERM	PREMATURE	MISCARRIAGE	MULTIPLE BIRTHS	ECTOPIC	LIVING

PAST PREGNANCIES

Type: vaginal, c-section, forceps, or vacuum **Anesthesia:** epidural, local, general, spinal

Complications: EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression If preterm labor, were medications used?____

Birthdate	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Place of Delivery	Complications

Reproductive History: Menstrual Cycle

Age at first period? _____

First day of last menstrual period _____

How often do you get your menstrual cycle? Every _____days, lasting _____ days.

Are your cycles? REGULAR IRREGULAR

Was this pregnancy conceived on birth control pills? YES NO

Last pap smear _____

Any abnormal Pap smears? YES NO

Height _____ Weight _____

Medications (include Over The Counter medications)	**Dose**	**Allergies to Medications**	**Reaction**
Surgery	**Date**		

Social History

Tobacco Use: Never Current _____# of Cigarettes per day Former, Quit at age_____

Any alcohol use: YES NO *If yes, the average number of drinks per week _____

Do you use street drugs? YES NO *If yes, the type used and last use _____

Any history of violence or abuse in your current household or in your past? YES NO

Do you have any cultural or religious considerations that need special attention? YES NO

Medical History: Do you know or have you ever had: (circle all that applies)

o Asthma o Autoimmune Disorder _____ o Bleeding Disorder o Blood Transfusion o Bone/ Joint Disease o Cancer (type)_____ o Chicken pox o Chicken pox vaccination o Chlamydia o Deep Vein Thrombosis o Infertility o Thalassemia (Italian, Greek, Mediterranean or Asian) o Neural Tube Defect (Meningomyelocele, Spinabifida, Oranencephaly)	o Depression o Diabetes Type I o Diabetes Type II o Elevated Cholesterol o Endometriosis o Fibroids o GERD/ Reflux o G.I. Illness o Gestational Diabetes o Heart Disease o Hepatitis A o Hepatitis B o Hepatitis C o Liver Disease o Infertility o Down Syndrome o Sickle Cell Disease o Muscular Dystrophy o Hemophilia o Kidney Disease/ UTI	o Other Inherited Genetic or Chromosomal Disorder o Maternal Metabolic Disorder (Insulin Dependent Diabetes) o HPV/ Genital Warts o High Blood Pressure o Thyroid Dysfunction o Seizures o Huntington's Chorea o Mental Retardation/ Autism o Tuberculosis o Tay Sachs Disease o Anesthetic Complications o Trauma o Cystic Fibrosis	o Breast o Gyn Surgery _____ o Uterine Anomaly o Patient or Baby's Father had a child with birth defects not listed above o Recurrent Pregnancy loss or still birth o Congenital Heart Defect o Other _____

STD's: Chlamydia Gonorrhea HIV Herpes Syphilis None
(circle all that applies)

How old will you be by your due date? _____

Is this pregnancy the result of infertility treatments? YES NO If so, what kind _____

Are you interested in screening for birth defects and chromosomal abnormalities? YES NO
(ultrasound and blood tests offered to all pregnant women)

Do you want a blood test to determine if you carry the gene for:

Cystic Fibrosis (Caucasian and Jewish patients at highest risk) YES NO
Sickle Cell Disease (African-American and Hispanic patients at highest risk) YES NO
Tay Sachs Disease (Jewish patients at highest Risk) YES NO

All above testing is optional and you can choose which disorder(s) to be tested. **CHECK WITH YOUR INSURANCE TO SEE WHAT YOU WILL BE RESPONSIBLE FOR.**

Patient's Signature:_____ Date: _____