TANGCHITNOB MD

MINIMALLY INVASIVE ROBOTIC SURGICAL GROUP FOR OBSTETRICS & GYNECOLOGY

PREGNANCY INSTRUCTIONS

Congratulations on your pregnancy!

Please read these instructions and do not hesitate to ask any questions that you have:

1. Please do not miss appointment if possible and please reschedule as soon as possible.

2. First 5 months of pregnancy requires routine prenatal testings:
   - OB initial visit: Prenatal blood tests, pap smear, vaginal cultures, prenatal vitamins, and first trimester if you request
   - At 15-20 weeks gestation: AFP or Amniocentesis if you request
   - At 20-26 weeks gestation: OB ultrasound if it is indicated
   - At 26-28 weeks gestation: Diabetes testing and rhogam injection if you have a negative RH blood type
   - At 35 weeks gestation: Group B strep culture

3. After 28 weeks gestation, you need to be seen every 2 weeks or sooner if indicated After 35 weeks gestation you need to be seen every week or sooner if indicated

4. Please do not hesitate to call Dr. Tangchitnob if you have any symptoms as following:
   - Contraction pain
   - Headache with upper abdominal pain
   - Abnormal vaginal discharge: bloody, watery, or excess
   - Decreased fetal movement
   - Fever

5. Try to have bed rest as much as possible. Left lateral position is preferred.

6. Avoid smoking, alcohol or any dangerous substances.

7. Avoid vaginal douching, tampons, and sexual intercourse.

1135 S Sunset Ave, Ste 102, West Covina, CA 91790 • Tel: (626) 338-5377 • Fax: (626) 851-8822

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PREVIOUS PREGNANCY HISTORY

Patient's Name: _____

NUMBER	YEAR	SEX	FULL TERM/ PRETERM	BIRTH WEIGHT	VAGINAL/ C-SECTION
1					
2					
3					
4					
5					
6					

PREVIOUS MEDICAL HISTORY:

☐ Diabetes ☐ Hypertension ☐ Asthma ☐ Heart ☐ Kidney

☐ Other: _____

PREVIOUS SURGICAL HISTORY:

☐ C-Section ☐ Appendectomy ☐ Gallbladder

☐ Other: _____

Medication: _____

Allergies: _____

Would you like sterilization after this pregnancy? ☐ YES ☐ NO

Would you like circumcision if you have a boy? ☐ YES ☐ NO

Name of Pediatrician: _____

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OBSTETRICS ULTRASOUND CONSENT

Ultrasound, as used in pregnancy, has never been proved to have any detrimental effect, either to the mother or to the baby. There is no radiation such as X-rays in pregnancy ultrasounds.

1. **DUE DATE:** By measuring the width of the baby's head and length of the thigh bone (femur), an accurate estimate of the due date can be made. However, it can be off from the real gestation age by up to 2 weeks.
2. **LOCATION OF THE PLACENTA:** If the placenta covers the mouth of the womb (Cervix), dangerous bleeding can occur at anytime during the pregnancy before the onset of labor. Evaluation of the placenta enables the mother with this condition to change their working activities and lifestyles, if necessary.
3. **TWIN PREGNANCY:** It is important to know if a mother has twins early in her pregnancy to give her optimal care for the best outcome.
4. **MALFORMATIONS** (Birth defect): All couples have a 2-3% risk of a major malformation of the fetus. This means of course, that there is at 97-98% chance of the baby not having a major malformation. The use of an ultrasound is not able to detect all of these malformations; therefore, there is no guarantee that a malformation is not present.
5. **FETAL GROWTH:** By comparing serial ultrasounds, the growth of the baby can be evaluated. This is especially important in twin pregnancies.
6. **FETAL POSITION:** Ultrasound can determine whether the baby is head position or in the breech position.
7. **FETAL SEX:** Ultrasound is able to determine fetal sex with approximately 90% accuracy. It depends on the age of the pregnancy and the position of the fetus.

I have read and understand all of the above. I want to have Dr. Tangchitnob perform the FIRST LEVEL ULTRASOUND study. I also was offered to have options of the provider to have ultrasound study performed during my pregnancy. I will accept the limitations of this study including all the consequences that may arise.

Patient's Signature: _____ Date: _____

Patient's Name: _____

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OB QUESTIONNAIRE

1. Do you accept that not every pregnancy will have a perfect outcome? ☐ YES ☐ NO
   Comments: _____
2. Would you keep pregnancy regardless if the baby has a birth defect or not? ☐ YES ☐ NO
   Comments: _____
3. Any family history of Birth Defect? ☐ YES ☐ NO
   Comments: _____
4. Any family history of Genetic Disease? ☐ YES ☐ NO
   (Tay Sachs, Cystic Fibrosis, Blood disease, etc.)
   Comments: _____
5. Do you want to have Amniocentesis if you are over 35 years old? ☐ YES ☐ NO
   Comments: _____
6. Previous OB History: C-Section, preterm labor, or toxemia Pregnancy? ☐ YES ☐ NO
   Comments: _____
7. Previous medical history: ☐ YES ☐ NO
   HTN, DM, CAD, Asthma, Kidney Disease, Seizure Disorder?
   Comments: _____
8. Previous Surgical History: Appendectomy, Cholecystectomy, Back Surgery? ☐ YES ☐ NO
   Comments: _____
9. Are you aware that pregnancy state may jeopardize your health? ☐ YES ☐ NO
   Comments: _____
10. Are you considering your pregnancy as high risk pregnancy? ☐ YES ☐ NO
    Comments: _____
11. I authorize testing of my blood for expanded AFP ☐ YES ☐ NO
    Comments: _____
12. I authorize testing of my blood for HIV screening test ☐ YES ☐ NO
    Comments: _____

I understand and accept the consequences of these decisions.

Patient's Signature: _____ Date: _____

Patient's Name: _____

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