CHRISTUS ST. VINCENT
Regional Medical Center
Women's Care Specialists

OB Questionnaire

Name	Address
Birth Date Age	City State Zip
Phone (Home) (Work)	Insurance Carrier/Medicaid #
Occupation Education (last grade completed)	Policy #
Language Spoken Ethnicity	Marital Status Single Married Widowed Divorced
Husband/Domestic Partner Name Phone	Emergency Contact Phone
Father of the Baby Phone	Referred By

Menstrual History

1st Day of Last Menstrual Period______
Definate_________Approximate_________Unknown_________Normal(amount/duration)________
Frequency________days Using birth control at conception__________ +pregnancy test date________

Medical/Family History (Please include self, parents, and grandparents)

	+ Pos/ o Neg	Details/Remarks Date/Treatment		+ Pos/ o Neg	Details/Remarks Date/Treatment
1.Diabetes			15.D (Rh) Sensitized		
2.Hypertension			16. Pulmonary (TB, Asthma)		
3.Heart Disease			17.Seasonal Allergies		
4.Autoimmune Disorder			18.Drug/Latex Allergies/Reactions		
5.Kidney Disease/History of UTI			19.Breast		
6.Neurologic/Epilepsy			20.GYN Surgery		
7.Psychiatric			21.Operations (year & reason)		
8.Depression/Postpartum Depression			22.Hospitalizations (year & reason)		
9.Hepatitus/Liver Disease			23.Anesthetic Complications		
10.Varicosities/Phlebitis			24.History of Abnormal Pap Smear		
11.Thyroid dysfunction			25.Date of Last Pap Smear		
12.Trauma/Violence			26.Uterine Abnormalities		
13.History of Blood Transfusion			27.Infertility		
		Amt/Day Prepreg /Current	28.ART Treatment		
14.Tobacco			29.Relevant Family History		

30.Alcohol			32.Cancers		
31.Illicit/Recreational Drugs			33.Other		

Past Pregnancies

Date/Year	GA Weeks	Labor Length	Birth Weight	Sex	Type of Delivery	Place of Delivery	Preterm Labor	Comments/ Complications

Genetic Screening/Teratology Counseling

Include patient, baby's father, or anyone in either family with:

	yes	no		yes	no
1.Patients age 35 years or older at estimated date of delivery			12.Cystic Fibrosis		
2.Thalassemia (Italian, Greek, Mediterranean, or Asian Background): MCV<80			13.Huntington's Chorea		
3.Neural Tube Defect (Meningomyelocele, spina bifida, or anencephaly			14.Mental Retardation/Autism		
4.Congenital Heart Defect			If yes, was person for fragile X?		
5.Down Syndrome			15.Other inherited genetic or chromosomal disorder		
6.Canavan disease (Ashkenazi Jewish)			16.Maternal Metabolic Disorder (Type I diabetes, PKU)		
7.Tay-Sachs (Ashkenazi Jewish)			17.Patient or baby's father had a child with birth defects not listed above		
8.Familial Dysautonomia (Ashkenazi Jewish)			18.Recurrent pregnancy loss, or a still birth		
9. Sickle Cell Disease or Trait (African)			19.Medications (supplements, vitamins, over the counter, or prescribed) illicit/recreational drug use since last menstrual period		
10.Hemophilia or Other Blood Disorder			20.If yes, please what was it, and how much:		
11.Muscular Dystrophy					

Infection History

	yes	no		yes	no
1.Live with someone with TB or exposed to TB			4.Hepatitus B, C		
2.Patient or partner has history of genital herpes			5.History of STD, Gonorrhea, Chlamydia, HPV, HIV, Syphilis		
3.Rash or viral illness since last menstrual period					

Do You Feel Safe At Home? Yes ______ No______

Other Questions/Concerns

Consent to Treat

I hereby consent to treatment including tests, procedures or medications directed by the providers

Signature of Patient or Legal Representative__________________________ Date_____/_____/_____

Assignment and Release

I have insurance coverage with ___________________________ Insurance Company and assign directly to Dr. _______________________________all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of my benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Patient or Legal Representative__________________________ Date_____/_____/_____

Advance Directive

I have an Advance Directive that I will provide to SVRMC for inclusion in my medical record.
I would like information about formulating an Advance Directive

I have received a copy of the "Your Right to Decide" brochure. ______________________(Initial)

Notice of Privacy Practices

I understand that St. Vincent Regional Medical Center is part of an organized healthcare arrangement that includes St. Vincent Hospital and Physician Practices, and all members of the SVH Medical staff and that these providers may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that the organized healthcare arrangement has the right to change this notice at any time. A current copy may be obtained by contacting hospital registration or clinics or by visiting the web site at www.stvin.org.

Notice of Patient Rights and Responsibilities

I understand that as a patient of St. Vincent Hospital or one of the Physician Practices owned by them, I have certain Rights and Responsibilities and I have been given information about them.

Acknowledgement of Receipt

My signature below constitutes my acknowledgement that I have been given copies of the Notice of Privacy Practices and Patient Rights and Responsibilities, and Advance Directive information has been made available to me

Signature of Patient or Legal Representative_______________________________ Date_____/_____/_____

If signed by other than patient, relationship____

Authorization for Disclosure of Protected Health Information
to persons involved in my care.

I hereby authorize CHRISTUS St. Vincent Medical Group to disclosed protected information for:

Name of Patient: ____
(Last) (First) (MI)

Date of Birth: _______/______/______ Age: _________ Phone: ______________________________

Social Security Number: ________________________

Address: ____
(Number) (Street)

Address: ____
(City) (State) (Zip)

My protected health information can be disclosed to family members, other relatives, a close personal friend, or other person(s) identified by me on this form for the purposes of assisting in their role as persons involved with or paying for my care.

Name of Person(s) to whom Protected Health Information can be disclosed: ______________________________

____

Relationship or involvement in Patient(s) care: ______________________________

____

This authorization and request shall not extend to records for treatment of Mental Health, Substance Abuse, Developmental Disability, and/or HIV. Further, I understand that this authorization is not a condition of admission or treatment and I make it voluntarily

Patient Signature: ____________________________________ Date: _____/_____/______

Witness Signature: ____________________________________ Date: _____/_____/______

Witness Name (please print): ____

Women’s Care Specialists
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To better serve you, we have transitioned into using Electronic Documentation. In order to comply with regulations regarding Electronic Documentation, we are required to ask the following questions:

Please check (√) one:

Primary Language:

	Arabic
	Chinese
	English
	French
	Italian
	Japanese
	Other
	Portuguese
	Russian
	Spanish

Race:

	American Indian or Alaskan Native
	Asian
	Black or African American
	Native Hawaiian or Other Pacific Islander
	White

Secondary Language:

	Arabic
	Chinese
	English
	French
	Italian
	Japanese
	Other
	Portuguese
	Russian
	Spanish

Ethnicity:

	Hispanic or Latino
	Not Hispanic or Latino

Patient refusal for above information ☐

Who is your Primary Care Provider?:____

Please list an Emergency Contact: Name:____

Relation: ______________________________ Phone #: ______________________

What is your preferred pharmacy? (Please specify which location or street) ______________________

Patient Name: ______________________________ DOB: ______________________