TRI-STATE PERINATOLOGY

4199 Gateway Blvd.
Newburgh, IN 47630
812-842-4550

CONSENT FOR MEDICAL TREATMENT

I,_____(or _____ for _____) hereby voluntarily consent to care encompassing diagnostic procedures and medical treatment by Dr. Fitzpatrick or his designees as necessary in his/her judgment at Tri-State Perinatology at The Women's Hospital (TSP). I have received sufficient information regarding the diagnostic procedures, including the purposes, risks and benefits of the procedures, and I have had an opportunity to ask any questions about the procedures. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees, representations, or warranties have been made to me regarding the results of treatments, examinations, or care at TSP.

I understand that I am entitled to a full explanation of services offered and I have the right to refuse at any time any individual services or portions thereof which are offered to be provided to me. I have read or had read to me and understand the information in this consent and have been given a copy of this form.

_____	_____
Signature	Date
_____	_____
Signature of Guardian/Relative/Representative	Date
_____	_____
Witness	Date

TRI-STATE
PERINATOLOGY
JOINTLY PHYSICIAN OWNED
at The Women's Hospital

Patient Information

Patient Name:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Date of Birth: Age:

Social Security #:

Street Address:

City: State: Zip:

Email:

Pharmacy:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: Relationship:

Phone:

Address:

City: State: Zip:

INSURANCE INFORMATION

Primary Insurance: Insured's Name:

Date of Birth: Social Security #:

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Employer:

Secondary Insurance: Insured's Name:

Date of Birth: Social Security #:

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Employer:

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PERMISSION TO DISCUSS MY CARE

Patient name	Birthdate

I permit the following information to be discussed with those of my family, friends or others listed below. I understand that if I want any of these persons to receive a copy of my records, I must complete and sign a separate 'Authorization' or 'Release of Information' form. Copies of my complete record can be obtained through the Medical Records Department. Copies of individual test results or office notes can be obtained from the physician office.

☐ Appts only
☐ Results/Plan of care
☐ My bill

Name	Relationship	Phone

☐ Appts only
☐ Results/Plan of care
☐ My bill

Name	Relationship	Phone

☐ Appts only
☐ Results/Plan of care
☐ My bill

Name	Relationship	Phone

☐ Appts only
☐ Results/Plan of care
☐ My bill

Name	Relationship	Phone

Discussion of results and plan of care will not include mental health counseling sessions for which a separate form is required.

In an emergency or if admitted to the hospital and unable to make my wishes known, I understand that my doctor and hospital staff may rely on the above permission to determine with whom they may discuss my care.

The above permissions can be changed by me at any time by notifying my doctor's office, Medical Records or The Women's Hospital Privacy Officer.

Patient Signature	Date
Printed Name	
Signature of lawful personal representative*	Telephone

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Patient History Form

Date of Assessment: _____ Referring Doctor: _____

Have you been a patient at TSP before? ☐ Yes ☐ No

Patient Name: _____ Race/Ethnicity: _____

Previous Last Name: _____

Religious Preference: _____ Date of Birth: _____

Age: _____ Place of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Last grade of school completed: _____ Marital Status: _____

Father of Baby's Name: _____ Father of Baby's Age: _____ Race/Ethnicity: _____

Emergency Contact: _____ Phone: _____

Do you have someone you can count on to help you through your pregnancy and with the baby? ☐ Yes ☐ No

If yes, who? _____

Do you have an Advanced Directive for Healthcare (a Living Will/Power or Attorney for Healthcare)? ☐ Yes ☐ No

If yes, please bring a copy to your appointment.

Insurance: _____ Under: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Any foreign travel within the past 12 months? ☐ Yes ☐ No

Pregnancy History

Have you ever been pregnant before? ☐ Yes ☐ No

If yes, how many times (include this pregnancy)?

How many were full term (>37 weeks)?

Number of miscarriages:

How many were pre-term (<37 weeks)?

Number of abortions:

Number of ectopic pregnancies:

Number of living children:

Multiple pregnancies (twins, triplets):

Last menstrual period ___/___/___ ☐ Definite ☐ Approximate ☐ Unsure of dates

Was it a normal period? ☐ Yes ☐ No

Age when got first period:

Are your periods typically regular? ☐ Yes ☐ No

How often do you have periods?

How long do they last?

Was this a planned pregnancy? ☐ Yes ☐ No

Did this pregnancy occur naturally? ☐ Yes ☐ No

If no, what type of fertility treatment?

If in vitro, please list transfer date:

Number of fetuses carrying:

Were you using contraception when you got pregnant? ☐ Yes ☐ No

If yes, what type?

When did you stop?

Parenting History

If you have had other children, are they in your care now? ☐ Yes ☐ No

If no, have you cared for them in the past?
☐ Yes (more than 3 months) ☐ Yes (less than 3 months) ☐ No

Have you ever raised any children other than you biological children (relatives, step children, etc.)?
☐ Yes ☐ No

Have you ever had to talk to the Department of Social Services about your parenting?
☐ Yes ☐ No

Due to lead poisoning concerns, do you live in a house built prior to 1978?
☐ Yes ☐ No

Medication History

Please list medications you are currently taking (include vitamins, over-the-counter medicines and herbal supplements). Please bring your medications with you to your appointment.

Medication	Dosage	Reason Taking

List medication allergies and reaction(s): _____

Check if allergic to:

❑ Seafood

❑ X-ray dye

❑ Tape or band aids

❑ Latex

❑ Food allergies (please list):

Have you ever had a blood transfusion? ☐ Yes ❑ No

Did you have a reaction? ☐ Yes ☐ No

Are you willing to receive blood/blood products if needed? ☐ Yes ❑ No

Medical History

Do you have asthma? ❑ Yes ❑ No

If yes, how often have you had coughing, wheezing or shortness of breath in the last month?

❑ All of the time
❑ Every day
❑ 3-6 times/week
❑ Twice/week
❑ 3-4 times/month
❑ Twice/month or less

If yes, how much time has your asthma kept you from participating in physical activities in the last month?

❑ Bothers me with any physical activity
❑ Bothers me with moderate activities
❑ Bothers me only with a great deal of activity
❑ None except during an attack

Have you ever been told you have tuberculosis? ❑ Yes ❑ No

Do you have any other lung problems/diseases? ❑ Yes ❑ No

Do you have a heart murmur? ❑ Yes ❑ No

Do you have mitral valve prolapse? ❑ Yes ❑ No

Do you have high blood pressure? ❑ Yes ❑ No

Have you ever had high blood pressure during a pregnancy? ❑ Yes ❑ No

Have you ever had a blood clot? (DVT, PE) ❑ Yes ❑ No

Do you have any liver diseases? ❑ Yes ❑ No

Do you have hepatitis? ❑ Yes ❑ No

Do you have any stomach or intestinal problems? ❑ Yes ❑ No

Do you have gall bladder problems? ❑ Yes ❑ No

Do you have kidney problems? ❑ Yes ❑ No

Do you get frequent urinary tract infections? ❑ Yes ❑ No

Do you have neurological problems? ❑ Yes ❑ No

Do you get migraines? ❑ Yes ❑ No

Do you have seizures? ❑ Yes ❑ No

Do you have anemia? ❑ Yes ❑ No

Do you have multiple sclerosis? ❑ Yes ❑ No

Do you have thyroid problems? ❑ Yes ❑ No ❑ Hyper ❑ Hypo

Have you ever been diagnosed with anxiety? ❑ Yes ❑ No

Have you been diagnosed with depression? ☐ Yes ☐ No

Have you been diagnosed with any psychiatric disorders? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No
☐ Juvenile ☐ Adult ☐ Insulin ☐ Pills ☐ Diet controlled

Have you ever had diabetes during a pregnancy? ☐ Yes ☐ No

Have you ever had problems with your breasts? ☐ Yes ☐ No ☐ Lump ☐ Cyst

Have you ever been diagnosed with infertility? ☐ Yes ☐ No

Have you ever had an abnormal pap smear? ☐ Yes ☐ No
☐ Biopsy ☐ Repeated ☐ Colpo ☐ Cryo/freezing ☐ Laser

Have they been normal since? ☐ Yes ☐ No

Have you ever been told you have uterine fibroids? ☐ Yes ☐ No

Do you have any uterine abnormalities? ☐ Yes ☐ No

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No

☐ Chlamydia ☐ Gonorrhea ☐ Trichomonas ☐ Syphilis ☐ Herpes ☐ Genital warts ☐ HIV
☐ Other: _____

Have you had any radiation exposure during your pregnancy (x-rays etc.)? ☐ Yes ☐ No

Have you taken any medication during your pregnancy? ☐ Yes ☐ No

Have you ever had surgery on your uterus, cervix, ovaries or fallopian tubes? ☐ Yes ☐ No

Have you ever had any surgery? ☐ Yes ☐ No

If yes, please list the surgery and the year done:

_____

_____

_____

Are you up to date with your immunizations? ☐ Yes ☐ No

Did you ever have chicken pox? ☐ Yes ☐ No

Any other medical issues not noted above? ☐ Yes ☐ No

_____

_____

Mental Health Screen

During the last 12 months, was there a time when you felt very sad, depressed or really down for longer than 2 weeks? ☐ Yes ☐ No

During the last 12 months, was there a time where you lost interest in things like hobbies or work that normally gives you pleasure? ☐ Yes ☐ No

During the last 12 months, was there a time lasting a month or more where you felt extremely stressed, worried, tense or like your nerves were getting bad? ☐ Yes ☐ No

Have you ever been on medication for depression or for your nerves? ☐ Yes ☐ No

If so, please list: _____

Have you ever received any other treatment for mental health problems? ☐ Yes ☐ No

If so, please list: _____

Questions about husband/partner (current and past):

Have you ever had a partner that made you feel unsafe? ☐ Yes ☐ No ☐ Current ☐ Past

Have you ever had a partner who put you down, insulted you or hurt your feelings? ☐ Yes ☐ No ☐ Current ☐ Past

Have you ever had a partner who hit, kicked, slapped, pushed or physically hurt you? ☐ Yes ☐ No ☐ Current ☐ Past

Have you ever had a partner who forced you to do anything sexually that you did not want to do? ☐ Yes ☐ No ☐ Current ☐ Past

When you were a child or teenager, were you ever physically, emotionally or sexually used? ☐ Yes ☐ No

Please check applicable responses related to smoking, alcohol use and drug use:

☐ I smoke regularly now, same as before I was pregnant.

☐ I smoke regularly now, but have cut down since I found out I was pregnant.

☐ I smoke every once in a while and have quit since I found out I was pregnant.

☐ I was not smoking around the time I got pregnant.

☐ I currently do not smoke cigarettes at all.

Did you drink alcohol before you were pregnant? ☐ Yes ☐ No, If yes, how much? _____

Have you drank alcohol during pregnancy? ☐ Yes ☐ No, If yes, how much? _____

Did you use drugs before pregnancy? ☐ Yes ☐ No, If yes, what drugs? _____

Have you used any drugs during pregnancy? ☐ Yes ☐ No, If yes, what drugs? _____

How often have you used drugs in pregnancy? ☐ Daily ☐ Weekly ☐ Monthly ☐ Every now and then

Have you ever received treatment for drug/alcohol abuse? ☐ Yes ☐ No

Genetic Screen

Your family history AND father of baby's family history

Are you 35 years of age or older or will be 35 by your due date? ☐ Yes ☐ No

Will father of baby be over 45 years of age by your due date? ☐ Yes ☐ No

Are you related by blood to your spouse/father of baby? ☐ Yes ☐ No

Have you had more than 2 miscarriages? ☐ Yes ☐ No

Any immediate family history of intellectual disability? ☐ Yes ☐ No

Any family history of chromosomal abnormalities (i.e. Down Syndrome, trisomy)? ☐ Yes ☐ No

Any family history of muscular dystrophy? ☐ Yes ☐ No

Any family history of sickle cell disease or thalassemia? ☐ Yes ☐ No

Who?

Any family history of neural tube defects (i.e. spina bifida)? ☐ Yes ☐ No

Any family history of thrombophilia or clotting disorders? ☐ Yes ☐ No

Any family history of hemophilia? ☐ Yes ☐ No

Are you (or father of baby) Jewish, French Canadian or Creole descent? ☐ Yes ☐ No

Are you (or father of baby) Italian, Greek or Mediterranean background? ☐ Yes ☐ No

Are you (or father of baby) Philippine or South East Asian ancestry? ☐ Yes ☐ No

Any family history of birth defects, heart defects (extra fingers, cleft lip/palate)? ☐ Yes ☐ No

Who? What?

Any family history of cystic fibrosis? ☐ Yes ☐ No

Any family history of diabetes? ☐ Yes ☐ No

Who?

Any family history of heart disease, stroke, or elevated blood pressure under 60 years of age? ☐ Yes ☐ No

Any family history of cancer under 50 years of age? ☐ Yes ☐ No

Any family history of other problems or medical issues not noted above? ☐ Yes ☐ No

How tall are you?

Pre-Pregnancy weight

Are you planning to breast feed your baby? ☐ Yes ☐ No

Have you breast fed before? ☐ Yes ☐ No

Any problems?

Taking breast feeding classes? ☐ Yes ☐ No

Delivery Date	☐☐/☐☐/☐☐ MM DD YY	☐☐/☐☐/☐☐ MM DD YY	☐☐/☐☐/☐☐ MM DD YY	☐☐/☐☐/☐☐ MM DD YY	☐☐/☐☐/☐☐ MM DD YY
Duration of Pregnancy	_____weeks	_____weeks	_____weeks	_____weeks	_____weeks
Was the pregnancy...	☐ miscarraige ☐ abortion ☐ ectopic ☐ live born ☐ stillborn	☐ miscarraige ☐ abortion ☐ ectopic ☐ live born ☐ stillborn	☐ miscarraige ☐ abortion ☐ ectopic ☐ live born ☐ stillborn	☐ miscarraige ☐ abortion ☐ ectopic ☐ live born ☐ stillborn	☐ miscarraige ☐ abortion ☐ ectopic ☐ live born ☐ stillborn
Mode of delivery	☐ vaginal ☐ c-section ☐ D&C	☐ vaginal ☐ c-section ☐ D&C	☐ vaginal ☐ c-section ☐ D&C	☐ vaginal ☐ c-section ☐ D&C	☐ vaginal ☐ c-section ☐ D&C
Infant's sex	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female
Onset of labor	☐ spontaneous ☐ induction	☐ spontaneous ☐ induction	☐ spontaneous ☐ induction	☐ spontaneous ☐ induction	☐ spontaneous ☐ induction
Length of labor	_____hours	_____hours	_____hours	_____hours	_____hours
If c-section, why?	☐ breech ☐ distress ☐ repeat	☐ breech ☐ distress ☐ repeat	☐ breech ☐ distress ☐ repeat	☐ breech ☐ distress ☐ repeat	☐ breech ☐ distress ☐ repeat
Type of anesthesia	☐ none ☐ epidural ☐ spinal ☐ general	☐ none ☐ epidural ☐ spinal ☐ general	☐ none ☐ epidural ☐ spinal ☐ general	☐ none ☐ epidural ☐ spinal ☐ general	☐ none ☐ epidural ☐ spinal ☐ general
How much did baby weigh?	____lbs____oz	____lbs____oz	____lbs____oz	____lbs____oz	____lbs____oz
Complications					
Delivery Hospital					
Doctor					