918 E. Pleasant Run Rd., #110 Cedar Hill, TX 75104
Phone: 469-206-9080
frontdesk@woodusobgyn.com

Prenatal Questionnaire
Please complete and do not leave blanks

______________________ Patient Name
______________________ Patient Date of Birth
______________________ Patient Social Security #

______________________ Street Address
______________________ City
__________ State
__________ Zip Code

______________________ Home Phone
______________________ Cell Phone
______________________ Work Phone

____ Name of Father of Baby

______________________ First Day of Your Last Period

☐ Yes ☐ No Was this normal?

☐ Yes ☐ No Is This your first pregnancy?

Miscarriages

______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation

Abortions

______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation
______________ Month/Year/Weeks Gestation

Ectopics

______________ Month/Year
______________ Month/Year
______________ Month/Year
______________ Month/Year

Prior Pregnancies

Month/Year	Sex	lb	oz	Delivery	Anesthetic	Length of Labor
________	☐ Male ☐ Female	_____	_____	☐ Vaginal ☐ C-Section	______________	__________
________	☐ Male ☐ Female	_____	_____	☐ Vaginal ☐ C-Section	______________	__________
________	☐ Male ☐ Female	_____	_____	☐ Vaginal ☐ C-Section	______________	__________
________	☐ Male ☐ Female	_____	_____	☐ Vaginal ☐ C-Section	______________	__________
________	☐ Male ☐ Female	_____	_____	☐ Vaginal ☐ C-Section	______________	__________

Are you currently taking prenatal vitamins? ☐ Yes ☐ No If yes, which type? ______________________

Height _______ Pre-Pregnancy Weight _______

Are you allergic to any medications? ____

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Patient Name _____ Patient # _____ Date _____

☐ Yes ☐ No 1. Will you be 35 year or older when the baby is due?

2. Have you, the baby's father or anyone in either of your families had any of the following disorders?

☐ Yes ☐ No • Down Syndrome

☐ Yes ☐ No • Other chromosomal abnormality

☐ Yes ☐ No • Neural tube defect (i.e. spina bifida (meningomyelocete or open spine) anencephaly

☐ Yes ☐ No • Hemophilia

☐ Yes ☐ No • Muscular dystrophy

☐ Yes ☐ No • Cystic fibrosis

☐ Yes ☐ No • If yes, indicate the relationship of the affected person to you or the baby's father

_____

☐ Yes ☐ No 3. Do you or the baby's father have a birth defect?

☐ Yes ☐ No 4. In any previous marriages, have you or the baby's father had a child born with one more birth defect(s) listed in questions 2 above?

☐ Yes ☐ No 5. Do you or the baby's father have any close relatives with mental retardation?
- If yes, indicate the relationship of the affected person to you or the baby's father.

_____

☐ Yes ☐ No 6. Do you, the baby's father, or a close relative of either of your families have a birth defect, any familial disorder or chromosomal abnormality not listed above?
- If yes, indicate the condition and the relationship of the affected person to you or the baby's father.

_____

☐ Yes ☐ No 7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses?

☐ Yes ☐ No
- Have either of you had a chromosomal study?
- If yes, indicate who and the results:

_____

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Patient Name _____

☐ Yes ☐ No

8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?
   - If yes, indicate who and the results:

   _____

☐ Yes ☐ No

9. If you or the baby's father of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalassemia?
   - If yes, indicate who and the results:

   _____

☐ Yes ☐ No

10. Excluding iron and vitamins, have you taken any medication or recreational drugs since being pregnant or since your last menstrual period? (Include nonprescription drugs)
    - If yes, give name of medication and time taken during pregnancy

    _____

* Any patient replying "yes to questions should be offered appropriate counselling. If the patient declines, further counseling or testing, this is noted in the chart. Given that genetics is a field in a state of flux, alterations or updates to this form will be required periodically.

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Dear Patient:

In accordance with the guideline from the American College of Obstetrics and Gynecology, all pregnant patients are being screened for hepatitis B antigen. This is to protect your infant as well as your family and yourself from the problems of this potentially lethal disease. In addition to screening all pregnant women, those that are at high risk may need further evaluation and/or treatment. Please read over the following list of possible high-risk groups. If you are a member of any of these groups, please indicate by checking in front of the appropriate statement.

- ☐ Asian, Pacific Island or Alaskan Eskimo descent, whether born in the Unites State or elsewhere
- ☐ Born in Haiti or Sub-Saharan Africa
- ☐ Work in a healthcare or public safety field
- ☐ Acute or chronic liver disease
- ☐ Work or reside in an institution for the mentally handicapped
- ☐ Work or treatment in a hemodialysis unit
- ☐ Rejection as a blood donor
- ☐ Blood transfusion on repeated occasions
- ☐ Frequent occupational exposure to blood in medical-dental settings
- ☐ Household contact with HBV carrier or hemodialysis patient
- ☐ Multiple episodes of sexually transmitted diseases
- ☐ Percutaneous use of illicit drugs
- ☐ None of the above

_____ _____

Patient Name Date

_____

Signature

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Sonogram Policy

Our physicians only schedule sonograms for our patients that they feel are medically necessary. Most, if not all insurance companies pay for medically necessary sonograms. However, the occasion may arise when a patient desires a sonogram to determine the sex of the baby or for other reasons that may not be medically necessary. In such a case, the physician will perform the sonogram for the patient but will ask that the patient pay for the procedure in advance. Thank you for your cooperation.

_____ _____
Patient Name Date

_____
Signature

The HIV Antibody Blood Test

Disclosure Consent and Release of Liability

The purpose of this form is to document that I or my physician has requested that my blood be tested to detect whether or not I have antibodies in my blood to the HIV virus, which may be a causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is new and its accuracy and reliability are still uncertain and that the test results may in some cases, indicate that a person has antibodies to the virus when the person does not (false positive) or the test may fail to detect that a person has the virus (false negative). I also understand that a positive blood test does not mean that I have AIDS. I understand that no warranty and no guarantee has been made to me as to the results of this test. I voluntarily request and consent to the administration of the test. The confidentiality of my medical records will be maintained. However, my physician or other health care providers, representatives of federal, state and local governmental agencies may ask to see the results for medical or scientific reasons or the results could be released by court order. Further, insurance companies and other third party payors may request these results if reimbursement is requested for the test from these third party sources. I hereby release Dr. Woodus, agents, and medical staff from responsibility and consequences resulting from the administration of the test.

_____ _____
Patient Name Date

_____
Signature