AFA OB/GYN
Obstetrical Medical History

Patient Name: _____ Date of Birth: _____

Date Form Completed: _____

*If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications ☐Yes ☐No Latex Allergy ☐ Yes ☐ No PCP _____
If yes please list:

_____

_____

2. Please Mark any condition that you have or have had in the past:

☐Cancer
☐Epilepsy/Seizers
☐Heart Disease/Murmur
☐High blood Pressure
☐Kidney disease
☐Hepatitis
☐vonWillebrand's disease or other bleeding disorders
☐Blood clotting disorder (e.g. phlebitis)
☐HIV/AIDS
☐Thyroid disorder
☐Headaches/ Migraines
☐Arthritis or Lupus
☐Frequent infections
☐Bowel disease
☐Diabetes
☐Eating disorder
☐Depression, Anxiety, or Psychiatric Illness
☐Asthma, Lung Disease, or TB
☐Anemia
☐Herpes
☐Sexually transmitted diseases
☐Recurrent urinary tract infections
☐Pulmonary Embolism
☐ Hepatitis/ Liver Disease
☐ Other Major Illnesses/ Medical Problems
☐ **Not Applicable**

Describe, if needed:

_____

_____

3. Please indicate any surgeries that you have had:

_____

_____

4. Please describe any health problems or symptoms that you are having at this time:

_____

_____

5. Do your or any family member have a history of problems with anesthesia? ☐Yes ☐No
If yes, please describe:

_____

_____

6. Do you have any religious objections to any form of medical treatment (e.g. refusal of blood transfusion)? ☐Yes ☐No
If yes, please describe:

_____

_____

7. Family History:

Breast Cancer _____ Uterine Cancer _____

Ovarian Cancer _____ Colon Cancer _____

Diabetes _____ Coronary Artery Disease _____

Deep Vein Thrombosis _____ Stroke _____

OBSTETRICAL HISTORY

Please complete the following table about your previous pregnancies in chronological order.
Please date all pregnancies including miscarriages.

No	Mo/Year	Hours In Labor	Weeks At Delivery	Type of Delivery	Anesthesia / Epidural	Birth Weight	Location	Baby's Name / Problems

MENSTRUAL HISTORY

Date First day of Last Period _____ Date of Period prior to last period _____
Was it normal? ☐Yes ☐No
How many days between the start of one period to the start of the next? _____ How long does it last? _____
Did you use any contraception? ☐Yes ☐No Date of last use_____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? _____

Have you ever had an abnormal Pap Test ? ☐Yes ☐No
If yes, when and how were you treated?

_____

What was the diagnosis?

_____

2. Have you ever had ☐ gonorrhea, ☐ chlamydia, or ☐ pelvic Inflammatory disease?
If yes, when, how, and where you treated? _____

3. Have you ever had herpes? ☐Yes ☐No
If yes, how often do you have outbreaks? _____
Have you ever had syphilis? ☐Yes ☐No
If yes, how, when and where were you treated? _____

4. Have you ever used an IUD (intrauterine device) for contraception? ☐Yes ☐No
If yes, please indicate when:

_____

Did you have any problem with the IUD?
If yes, please describe:

_____

5. Have you been treated for infertility? ☐Yes ☐No
If yes, please describe when and treatment received:

_____

_____

6. Do you have any other concerns related to your past health history? ☐Yes ☐No
If yes, please list:

_____

_____

EXPOSURES AFFECTING HEALTH

1. Do you smoke cigarettes? ☐Yes ☐No
If yes, how many packs per day? _____

2. Do you drink alcoholic beverages? ☐Yes ☐No
If yes, how often? What type of drinks? _____

_____

3. Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines:

4. Please list any recreational substances used since your last period (e.g., cocaine, marijuana):

5. Do you have any reason to believe you may have been exposed to AIDS (e.g., a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)? ☐Yes ☐No

6. Are you ever exposed to chemicals or radiation (e.g., X-rays)? ☐Yes ☐No
If yes, please describe:

7. Are you on a restricted diet? ☐Yes ☐No
If yes, please describe:

8. Have you received the Tdap (Tetanus-Diphteria-Pertussis) vaccine? ☐Yes ☐No
If yes, when: _____

9. Have you ever had MRSA (Methicillin-resistant Staphylococcus aureus)? ☐Yes ☐No
If yes, when? _____

FAMILY HISTORY & GENETIC SCREENING

1. Have you or has the baby's father / donor had a child born with a birth defect? ☐ Yes ☐No
If yes, please describe:

2. Did either you or the baby's father / donor have a birth defect? ☐Yes ☐No
If yes, please describe:

3. Please describe any abnormalities that have occurred in children of your family or the baby's father's/ donor's family (e.g., mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):

4. Do you or does the baby's father / donor have a history of pregnancy losses (miscarriages or stillborn)? ☐Yes ☐No
If yes, have either of you had genetic counseling? ☐Yes ☐No
If yes, have either of you had chromosomal testing? ☐Yes ☐No
Where and what were the results?

5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you or the baby's father / donor is of one of these backgrounds:
Eastern Europe Jewish ancestry ☐Yes ☐No
If yes, have you had Tay-Sachs screening tests? ☐Yes ☐No
If yes, have you had a Canavan screening test? ☐Yes ☐No
Date _____ Result_____

African American☐ Yes ☐No
If yes, have you had sickle cell screening? ☐Yes ☐No
Date _____ Result_____

European Ancestry ☐Yes ☐No
If yes, have you had cystic fibrosis screening? ☐Yes ☐No

Mediterranean Ancestry or Southeast Asian Ancestry? ☐Yes ☐No
If yes, have you had screening for inherited forms of anemia such as thalassemia ? ☐Yes ☐No

6. Please list any other concerns you have about birth defects or inherited disorders:

7. Will you be 35 years or older at the time the baby is born? ☐Yes ☐No

8. Will the father/donor be 50 years or older? ☐Yes ☐No

PSYCHOSOCIAL SCREENING

1. Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments? ☐Yes ☐No

2. Do you feel unsafe where you live? ☐Yes ☐No

3. In the past 2 months, have you used any form of tobacco? ☐Yes ☐No

4. In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks? ☐Yes ☐No

5. In the past year, have you been threatened, hit, slapped, or kicked by anyone you know? ☐Yes ☐No

6. Has anyone forced you to perform any sexual act that you did not want to do? ☐Yes ☐No

7. On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High

8. How many times have you moved in the past 12 months? _____

9. Is this a planned pregnancy? ☐Yes ☐No
   Is this a wanted pregnancy? ☐Yes ☐No

PRENATAL GENETIC SCREENING

Genetic screening includes you, the baby's father / donor, or anyone in either family.

	Yes	No
Patient (only) is 35 years of age or older?	____	____
Italian, Greek, Mediterranean, or Oriental background?	____	____
Neural tube defect (meningocele, myelomeningocele, anencephaly)?	____	____
Congenital heart defect?	____	____
Down Syndrome?	____	____
Jewish or French Canadian (TaySach's)?	____	____
Sickle Cell disease or trait?	____	____
Hemophilia?	____	____
Muscular Dystrophy?	____	____
Cystic Fibrosis?	____	____
Huntington's Chorea?	____	____
Mental retardation?	____	____
If yes, was the person tested for Fragile X?	____	____
Autism?	____	____
Other inherited genetic or chromosomal disorders?	____	____
More than 3 first trimester spontaneous abortions or stillbirth?	____	____
Do you have cats or other household pets?	____	____
Other significant family history?	____	____

Print name _____

Patient Signature_____ Date_____

Patient Assignment of Benefits Form

Name: _____ **D.O.B.**_____

Phone number our staff is able to leave detailed medical information: _____

I authorize AFA OB/GYN to release my medical information including office visits, lab results, and treatment plan to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize AFA OB/GYN to release my medical information to the person(s) listed above which may contain information regarding: (please initial)

_____ STD results, HIV/AIDS testing _____Drug, alcohol, or mental health treatment

Signature: _____ **Date:**_____

Assignment of Benefits: I assign my benefits to be paid directly to AFA OB/GYN and understand that I am financially responsible for all services that are not covered.

Signature: _____

Release of Information: I authorize AFA OB/GYN to release any information required to process this claim to my insurance company or other party involved in reimbursement for the claim, which may include:

*Information about genetic testing
*Information related to communications with a psychotherapist, psychologist, social worker, or other allied mental health professional or human services professional
*Information about research involving controlled substances
*Abortion consent forms
* Mammography records
*Information about family planning services
*If I am a minor, information about my treatment and diagnosis (except to my parents)

Signature: _____

HIPAA Privacy Policy: I acknowledge that I have read the practice's Notice of Privacy Practices.

Signature: _____

AFA Obstetrics & Gynecology
Patient Financial Policy

We have adopted the following financial policy to avoid any misunderstanding between you and this office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions about bills or billing pertaining to your care from AFA Obstetrics & Gynecology, please call our billing department at 978-371-1396 option #5.

Please return this form to the receptionist once you have reviewed and signed it. A copy will be provided to you upon your request.

Insurance: We participate with most managed care plans. If you are insured by a plan with which we do not participate, then payment is required at each visit. Your insurance policy if a contract between you and your insurance company and it is your responsibility to know your own coverage. We will process your insurance claim for you if you assign the benefits to us. In other words, you give us permission to bill your insurance company directly and then they will pay us directly. You will be responsible for providing correct insurance information at each visit. You are responsible for obtaining referrals for services if required by your plan. All medical treatment and services that are not covered by your plan will be your responsibility. Patients are responsible for all deductibles, co-payments, non-covered services and out of network services. All co-payments are due at the time of the visit. Ultrasounds and lab work, although they can be performed in our office, are an outside service and therefore bill independently from AFA.

No Insurance Coverage: Full payment is expected at the time of service. We accept Visa, Discover, MasterCard, and checks.

Minor Patients: The adult accompanying the patient and the parent or guardian will be responsible for all services rendered to minor patients.

Delinquent Accounts: Payment is due upon receipt of a statement. If your account becomes delinquent, we will make every effort to collect the debt incurred prior to being sent to a collection agency and possibly being dismissed from the practice.

I have read and fully understand the financial policy and agree to the terms.

_____ _____

Name of Patient (print) Patient's Date of Birth

_____ _____

Signature of Patient or Guardian Today's Date

PATIENT CONSENT FOR MASS HIWAY

The Massachusetts Health Information Highway (Mass HIway) is the secure statewide computer network that allows for the electronic transfer of medical information between healthcare providers that is intended to improve the quality and safety of patient care. I have received and had an opportunity to review the "Mass HIway: Fact Sheet for Patients" provided to me by a physician practice affiliated with Emerson Hospital and Emerson Physician Hospital Organization (the "Practice"). I hereby give the Practice permission to use MassHIway to:

1. Send to the Mass HIway my name, date of birth, gender, email, home address, phone number, and medical record number so that my other providers using Mass HIway know I received care from the Practice and can ask for my medical information when needed for my care.

2. Request, send, and receive my medical information from and to my other providers who also use the Mass HIway. I understand that this information may include information about mental health, HIV test results, sexually transmitted diseases, domestic violence, sexual assault, substance abuse records, reproductive health concerns and genetic testing results.

3. I understand that I may withdraw my permission for the Practice to share information ("Opt-out") at any time by submitting a request in writing. The Opt-out notice can be sent to the Practice.

Print Patient Name	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date of Signature
Print Name of Patient's Legal Representative (if applicable)	Relationship to Patient

ATTENTION

Effective immediately if you have **MassHealth PCC** plan and are having any ultrasounds in our office and are **not pregnant** you will need to request a referral from your PCP otherwise these services will not be covered. Please ask your primary care for a referral to;

Premier Diagnostic Services

NPI #1659377802

Effective 6/1/18 if you have **Tufts Health Together** and are pregnant and part of the **Atrius** Network you will need to get a referral from your PCP BEFORE you have any ultrasounds, otherwise these services will not be covered by your insurance. Please have referrals made out to;

Tamara Takoudes

NPI #1669404109