

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:

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

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 you 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-Diphtheria-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 is 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