Name: _____ **Date of Birth:** _____

IF YOU HAVE HAD ANY OF THESE ISSUES IN THE PAST PLEASE CHECK THE BOX BELOW:

- ☐ Personal History of Diabetes (**not** during pregnancy)
- ☐ Personal History of High Blood Pressure
- ☐ Personal History of Kidney Disease
- ☐ Lupus
- ☐ Blood Clots in Legs or Lungs
- ☐ History of Heart Problems/Disease
- ☐ Currently pregnant with twins
- ☐ History of preterm delivery (less than 36 weeks)
- ☐ History of loss of infant while pregnant in 2nd-3rd trimester
- ☐ Antiphospholipid Antibody Syndrome
- ☐ Prior infant with health or genetic problems
- ☐ **Family** history of genetic problems
- ☐ Hemoglobinopathy (a hereditary blood disorder)

Explain: _____

- ☐ Rh negative blood type (causing problems during or prior to pregnancy)
- ☐ Neonatal death

WOMEN'S MEDICAL NEW OB FORM

Please complete this form and return it IMMEDIATELY. This helps us get a lot of the paperwork done before you come in for your prenatal consult and cuts down on the time you have to wait. Thank you.

FOR OFFICE USE ONLY

APPOINTMENT

Date _____

Time _____

Day _____

SCHEDULED BY _____

PROOF OF PREGNANCY ☐ **Yes** ☐ **No**

+UPT at WMC ☐ **Yes** ☐ **No**

Name _____ **DOB** _____ **Social Security #** _____

Address _____ **City** _____ **State** _____

Phone Number (HOME) _____ (CELL) _____

1. First day of your last menstrual period? _____ Are you certain? ☐ YES ☐ NO
2. Is this a planned pregnancy? ☐ YES ☐ NO
3. Are you happy with the pregnancy? ☐ YES ☐ NO
4. Current HEIGHT _____ WEIGHT _____
5. Do you have any medication ALLERGIES? ☐ YES ☐ NO
   If yes, what are you allergic to and what happens? _____
6. Have you had care for this pregnancy at another clinic? ☐ YES ☐ NO If yes, where? _____
   If yes, what are you allergic to and what happens? _____

SINCE YOUR LAST MENSTRUAL PERIOD

7. Have you had any vaginal bleeding or spotting? ☐ YES ☐ NO
   Did you have bleeding as much as a period? ☐ YES ☐ NO Spotting only? ☐ YES ☐ NO
   How often have you had the bleeding/spotting? _____
8. Have you had any nausea? ☐ Occasional ☐ Frequent ☐ None Vomiting? ☐ Occasional ☐ Frequent ☐ None
9. Have you had any breast tenderness? ☐ YES ☐ NO
10. Have you had any abdominal pain? ☐ YES ☐ NO
11. Have you had any vaginal discharge? ☐ YES ☐ NO
12. Have you had any headaches? ☐ YES ☐ NO
13. Have you had a fever above 101 degrees? ☐ YES ☐ NO
14. Have you had any illnesses? ☐ YES ☐ NO
15. Have you had any x-rays? ☐ YES ☐ NO
16. Have you taken any non prescription medications? ☐ YES ☐ NO If yes, please circle below:
    Tylenol Ibuprofen Aspirin Advil Sudafed NyQuil Tums Maalox Mylanta Pepto Bismal Other _____
17. Have you taken any prescription medications? ☐ YES ☐ NO If yes, list: _____
18. Are you?
    Please check one: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ In Relationship
19. **FATHER OF BABY**
    Name _____
    Race _____
    Age _____
    Occupation _____
20. **HAVE YOU EVER BEEN SEEN HERE?** ☐ YES ☐ NO
    If so, when? _____
    Have you ever been seen here using another name?
    ☐ YES ☐ NO
    If yes, what was the name? _____

21. Who do you live with? _____

Do you have any pets? ☐ YES ☐ NO If yes, what type? _____

22. Do you work outside the home? ☐ YES ☐ NO If yes, do you work ☐ FULL TIME ☐ PART TIME

What type of work do you do? _____

23. What is your HIGHEST level of education? _____

24. What is your race? _____

25. Do you have any religious preference? _____

26. Do you exercise on a regular basis? ☐ YES ☐ NO What type of exercise? _____

27. Are you currently in a monogamous relationship? (only one sex partner) ☐ YES ☐ NO

Or do you have multiple sex partners? ☐ YES ☐ NO

28. Have you used any type of birth control in the past year? ☐ YES ☐ NO

Circle all that apply

Birth Control Pills When did you STOP taking them? _____

Depo Provera Shot When was your last Shot? _____

Condoms Other: IUD Nexplanon NuvaRing Dates removed: _____

29. Do you smoke? ☐ YES ☐ NO CURRENTLY how many per day? _____

FORMER date stopped _____ ☐ NEVER

Does anyone in the home smoke? ☐ YES ☐ NO If yes: ☐ Inside ☐ Outside

30. Do you drink alcohol CURRENTLY? ☐ YES ☐ NO FORMER date stopped _____ ☐ NEVER

31. Have you used any street drugs? ☐ YES ☐ NO

If yes, what type? _____ Date last used? _____

32. Do you use medical marijuana? ☐ YES ☐ NO

33. Do you wear your seat belt? ☐ ALWAYS ☐ OCCASIONALLY ☐ RARELY ☐ NEVER

34. Do you feel safe in your personal relationship? _____

FAMILY HISTORY check all that apply

MOTHER

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

FATHER

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

BROTHER

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

SISTER

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

AUNT

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

UNCLE

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

MATERNAL GRANDMOTHER (your mom's mom)

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

MATERNAL GRANDFATHER (your mom's dad)

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

PATERNAL GRANDMOTHER (your dad's mom)

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

PATERNAL GRANDFATHER (your dad's dad)

☐ wears glasses/contacts ☐ deceased ☐ alive ☐ alzheimers ☐ anemia ☐ asthma
☐ blood clot in legs ☐ cancer (type and age diagnosed) _____
☐ depression ☐ diabetes type 1 or 2 ☐ gallbladder disease ☐ gallstones ☐ lupus
☐ hearing problems ☐ hep B ☐ high blood pressure ☐ kidney disease ☐ TB
☐ migraines ☐ obesity ☐ osteoporosis ☐ psychiatric problems
☐ scleroderma ☐ stroke ☐ thyroid (hyper or hypo) ☐ Unknown

FAMILY HISTORY FOR YOU AND THE FATHER OF THE BABY

Genetic disorders ☐ YES ☐ NO If yes, who? _____ Type _____
Twins ☐ YES ☐ NO If yes, who? _____
Down Syndrome ☐ YES ☐ NO If yes, who? _____
Cystic Fibrosis ☐ YES ☐ NO If yes, who? _____
Blood disorders ☐ YES ☐ NO If yes, who? _____ Type _____
Neural Tube Defects ☐ YES ☐ NO If yes, who? _____
Tay-Sachs ☐ YES ☐ NO If yes, who? _____
Muscular Dystrophy ☐ YES ☐ NO If yes, who? _____
Seizure ☐ YES ☐ NO If yes, who? _____
3 or more miscarriages ☐ YES ☐ NO If yes, who? _____
Multiple Sclerosis ☐ YES ☐ NO If yes, who? _____
Stillborn babies ☐ YES ☐ NO If yes, who? _____

Other inherited genetic/chromosomal disorders ☐ YES ☐ NO If yes, who? _____

YOUR PAST MEDICAL HISTORY

Chemical abuse	☐ YES	☐ NO
Surgery	☐ YES	☐ NO
Trauma	☐ YES	☐ NO
Transfusion	☐ YES	☐ NO
Diabetes Mellitus	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
Thyroid disease	☐ YES	☐ NO
Cardiac disease	☐ YES	☐ NO
Multiple gestation	☐ YES	☐ NO
Gallbladder disease	☐ YES	☐ NO
Bleeding disorder	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
TB	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Renal disease	☐ YES	☐ NO
Recurrent UTI's (3 or more per year)	☐ YES	☐ NO
Migraines	☐ YES	☐ NO
Decreased Hearing	☐ YES	☐ NO
Decreased Vision	☐ YES	☐ NO
Hepatitis B	☐ YES	☐ NO
Colitis	☐ YES	☐ NO
Seizure disorder	☐ YES	☐ NO
Psychiatric disorder	☐ YES	☐ NO
Do you wear glasses or contacts?	☐ YES	☐ NO
STD	☐ YES	☐ NO

If yes, what type: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphillis ☐ Condyloma

What years were you treated? _____

SURGICAL HISTORY

List all surgeries and dates of surgery

_____

_____

PAST GYNECOLOGIC HISTORY

Age you had your first period _____

Are your periods regular? ☐ YES ☐ NO

How many days between periods? ☐ 21 days or less ☐ 28-31 days ☐ 35 days or more ☐ Other _____

How many days does each period last? _____

Is your flow ☐ LIGHT ☐ MODERATE ☐ HEAVY

GYN surgery? ☐ YES ☐ NO If yes, type and date _____

Abnormal PAP ☐ YES ☐ NO If yes, when? _____

When was your last PAP? _____

Uterine Anomaly ☐ YES ☐ NO

Infertility ☐ YES ☐ NO

PAST OBSTETRICAL HISTORY

How many pregnancies have you had? _____

How many full term deliveries? 37-40 weeks _____

How many pre-term deliveries? 21-36 weeks _____

How many miscarriages? Less than 20 weeks _____ Please list date and how many weeks below.

Have you ever had an ectopic (tubal) pregnancy? ☐ YES ☐ NO

How many pregnancy terminations? _____ Dates and gestational age _____

How many living children do you have? _____

SUMMARY OF PREGNANCIES, DELIVERIES, ABORTIONS, MISCARRIAGES

Date	**How many weeks**	**Length of Labor** (How many hours did you have pains?)	**Delivery: Vaginal or C-Section** (If vaginal, forceps or suction used?)	**Anesthetic** Epidural, IV med or put to sleep	**Sex of Baby**	**Baby's Birth weight**	**Complications** (Use space below if needed)	**City/State and Dr. Name** (City/State you delivered and Dr. who delivered baby)

WOMEN'S MEDICAL CENTER PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

DATE: _____

Patient Legal Name _____

If Minor, Parent or Legal Guardian Name _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Birth Date** _____

Cellular Phone _____ **Social Security #** _____

Message Phone _____ **Referred by** _____

Patient employed by _____ **Occupation** _____

Business Phone _____ **Are calls allowed?** ☐ **Yes** ☐ **No**

Emergency Contact (not at same number) _____ **Phone** _____

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

Race ☐ **American Indian** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian** ☐ **White** ☐ **Other**

Ethnicity ☐ **Hispanic or Latino** ☐ **Non Hispanic or Latino** **Primary language** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: **Name of Insurance Company:** _____

Address of Insurance Company _____

Insurance Number _____ **Group #** _____

Name of Policy Holder AND relationship to you _____

Home Phone _____ **Birth Date** _____ **Social Security #** _____

Employed by: _____ **Business Phone** _____

SECONDARY INSURANCE **Name of Insurance Company:** _____

Address of Insurance Company _____

Insurance Number _____ **Group #** _____

Name of Policy Holder AND relationship to you _____

Home Phone _____ **Birth Date** _____ **Social Security #** _____

Employed by: _____ **Business Phone** _____

DO YOU HAVE AN ADVANCE DIRECTIVE? ☐ Yes ☐ No

If no, would you like information on it? ☐ **Yes** ☐ **No**

AUTHORIZATION OF CARE

Authorization is given to Women's Medical Center, its providers and employees to provide services and administer provider orders. Certain procedures require a separate consent form.

_____ _____

Patient signature AND legal guardian signature (if patient is a minor) **Date**

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the physician/provider for services. Failure to pay any balance due by the undersigned may involve a collection agency or attorney. It is understood and agreed that reasonable attorney fees are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned, agrees to pay all charges not paid in full to Women's Medical Center by a third-party payer.

_____ _____

Patient signature AND legal guardian signature (if patient is a minor) **Date**

OBSTETRICS | GYNECOLOGY | GYNECOLOGIC SURGERY

2000 W. 21st St., Suite A-1, Clovis, NM 88101 | 575-762-8055 | www.womensmedicalofclovis.com

Date: _____

Name:_____ DOB: _____

Which of the following is your **preferred** contact?

- ○ HOME PHONE:_____
- ○ CELL PHONE: _____
- ○ VOICE MAIL/ANSWERING MACHINE
- ○ EMAIL: _____

Checking the above information gives Women's Medical Center, LLP permission to call you and/or leave a message. This also gives the doctor or representative permission to give you results via phone; we will not leave test results on a voice mail or answering machine without further permission.

Patient Signature:_____

WOMEN'S MEDICAL CENTER

"Consent to Use and Disclosure of Protected Health Information"

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Women's Medical Center, LLP or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Women's Medical Center, LLP may or may not agree to restrict the use or disclosure of your protected health information

If Women's Medical Center, LLP agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You make revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Women's Medical Center, LLP reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Women's Medical Center, LLP to use and disclose my health information in accordance with it.

Name of Patient (Print or Type) _____

Signature of Patient _____

Date _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____

WOMEN'S MEDICAL CENTER

"Notice of Privacy Practices"

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Women's Medical Center, LLP. For example, information on the services your received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be used to disclose to enforcement agencies, without permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures requiring your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information.

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

Women's Medical Center Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require the requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Lonnie Ray, Privacy Officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to:

Lonnie Ray, Privacy Officer
Women's Medical Center, LLP
2000 W. 21st St., Suite A-1
Clovis, NM 88101

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against by filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Lonnie Ray, Privacy Officer
Women's Medical Center, LLP
2000 W. 21st St., Suite A-1
Clovis, NM 88101

Effective Date

This Notice is effective April 14, 2003.