R.A. Pastoriza, M.D.

Laura McCully, C.N.M., M.S.

www.womenfirsthealth.com

Women first health services

1100 east michigan avenue
suite 205
jackson, michigan 49201
phone 517.787.6838
fax 517.787.5623

Welcome to Women First Health Services! Your appointment is scheduled for [] at []. If you cannot make this appointment, please notify our office at least 24 hours in advance to avoid being charged a missed appointment fee. You may reach our office between the hours of 8am-12pm and 1pm-5pm Monday-Friday. Please note that we have summer hours (Memorial Day-Labor Day) of 7am – 11am and 12pm – 4pm.

Please bring the following to your appointment:

- **All Medical Records pertinent to this visit**. Please call your referring doctor to obtain copies of your records prior to your appointment with us.
- **Insurance card(s)**. If you have insurance that we do not participate with, or if you do not have office visit coverage, payment for services is expected at the time of your visit. Some insurances require an authorization from your primary care physician. If you are unsure whether you need a prior authorization, please contact your primary care physician or insurance company. It is your responsibility to get authorization and to know your benefits.

Should you have a medical question that needs to be directed to the nursing staff or physician, please call our office at 517.787.6838. A message will be taken and a return call will be made as soon as possible. For prescription refills, please leave a message with your name, the prescription and the name of the pharmacy you would like us to call. Please allow 24 hours for your prescription to be refilled.

In case of an after-hours emergency, please call 517.787-6500 for the on-call physician or head directly to Allegiance Hospital.

Please note that due to the obstetrical nature of our practice, Dr. Pastoriza may get called out during office hours for emergent deliveries. We make every effort to keep appointment times on schedule, and will do our best to notify you ahead of time should such an instance occur.

We look forward to meeting you.

-The Staff of Women First Health Services

Patient Name Date of Birth

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Today's Date:_____ **Primary Care Physician**:_____

Patient's Name:_____ **Date of Birth**:_____

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African America ☐ Native Hawaiian or Other Pacific Islander ☐White

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino **Marital Status**: ☐Married ☐Single☐Widow

Preferred Language:_____ **Social SecurityNo**.:_____

Address:_____ **City**:_____ **Zip**:_____

Home Phone No.:(_____)_____ **Cell Phone No**.:(_____)_____

Email:_____**Preferred Method of Contact**: ☐Home ☐Mobile ☐Email ☐Mail

Employer Name:_____ **Employer Phone No**.:(_____)_____

Emergency Contact:_____**Emergency Phone No**.:(_____)_____ ____

Allergies:_____

Preferred Pharmacy:_____**Pharmacy Phone No.:(_____)**_____

Pharmacy Address:_____

MEDICAL INSURANCE #1:_____ **Phone No.:(_____)**_____

Policy No.:_____ **Group No.:**_____

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

Subscriber's Employer:_____ **Employer Phone No.**_____

MEDICAL INSURANCE #2:_____ **Phone No.:(_____)**_____

Policy No.:_____ **Group No.:**_____

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

Subscriber's Employer:_____ **Employer Phone No.**_____

WFHS EMPLOYEE VERIFICATION INITIALS_____

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AUTHORIZATION / RESPONSIBILITY AGREEMENT

I give Women First Health Services the legal authorization to bill my medical insurance company for services provided by Women First Health Services on my behalf. I authorize payment directly to Women First Health Services. I understand it is still my responsibility to make sure the bill is paid in a reasonable time and if, for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I understand that I am financially responsible to Women First Health Services for charges not covered by this assignment. I understand that it is my responsibility to obtain referrals as required by my insurance plan. I further agree in the event of non-payment, to bear the cost of collection, and / or court costs and reasonable legal fees should this be required. I authorize Women First Health Services to release any information regarding my medical history, symptoms, treatment, examination results or diagnosis to any of my insurance companies in order to process a claim for benefits and payment. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand I will be charged a no show fee for broken appointments without 24 hours notice.

IF PATIENT IS UNDER THE AGE OF 18, THIS FORM MUST ALSO BE SIGNED BY A PARENT OR LEGAL GUARDIAN!

PATIENT NAME:_____

PATIENT SIGNATURE:_____**DATE:**_____

PARENT/LEGAL GUARDIAN SIGNATURE_____

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NEW OBSTETRICAL HISTORY			
Patient Name: Patient Name			Date:
Address:			City:
State/Zip:	Date of Birth:		Referred By:
Primary Provider/Group:		Provider Phone:	
Emergency Contact: Phone:	Relationship to Patient:		
Total Pregnancies:	Full Term:	Premature:	Abortion Induced:
Abortion Spontaneous:	Ectopic:	Multiple Births:	Living:

MENSTRUAL HISTORY

On Birth Control at Concept: ☐Yes ☐No Menses Monthly ☐Yes ☐No Prior Menses – Date: Frequency: days

Date of Last Menstrual Period:
☐Definite ☐Unknown ☐Final ☐Approx (Month Known) ☐Normal Amount / Duration

PAST PREGNANCIES (LAST SIX)

Date Month/Yr.	GA Wks.	Length of Labor	Birth Weight	Sex F/M	Type Delivery	Anes.	Place of Delivery	Pre Term Labor	Comments
				☐ F ☐ M				☐ Yes☐ No	
				☐ F ☐ M				☐ Yes☐ No	
				☐ F ☐ M				☐ Yes☐ No	
				☐ F ☐ M				☐ Yes☐ No	
				☐ F ☐ M				☐ Yes☐ No	
				☐ F ☐ M				☐ Yes☐ No	
				☐ F ☐ M				☐ Yes☐ No	

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MEDICAL HISTORY

	Detail Positive Remarks Include Date & Treatment				Detail Positive Remarks Include Date & Treatment	
Diabetes	☐Yes ☐No	[]		D(Rh) Sensitized	☐Yes ☐No	[]
Hypertension	☐Yes ☐No			Pulmonary (TB, Asthma)	☐Yes ☐No	
Heart Disease	☐Yes ☐No			Seasonal Allergies	☐Yes ☐No	
Autoimmune Disorder	☐Yes ☐No			Drug/Latex Allergies	☐Yes ☐No	
Kidney Disease/UTI	☐Yes ☐No			Reactions		
Neurologic/Epilepsy	☐Yes ☐No			Breast	☐Yes ☐No	
Psychiatric	☐Yes ☐No			GYN Surgery	☐Yes ☐No	
Depression/Postpartum Depression	☐Yes ☐No			Oper./Hospitalizations (Yr./Reason)	☐Yes ☐No	
Hepatitis/Liver Disease	☐Yes ☐No			Anesthetic Complications	☐Yes ☐No	
Varicosities/Phlebitis	☐Yes ☐No			History of Abnormal Pap	☐Yes ☐No	
Thyroid Dysfunction	☐Yes ☐No			Uterine Anomaly/Des	☐Yes ☐No	
Trauma/Violence	☐Yes ☐No			Infertility	☐Yes ☐No	
History of Blood Transfus.	☐Yes ☐No			Art Treatment	☐Yes ☐No	
	Amt/Day Pre Preg	Amt/Day Preg	# Yrs Use	Relevant Family History	☐Yes ☐No	
				Other: []	☐Yes ☐No	
Tobacco	[]	[]	[]			
Alcohol	[]	[]	[]			
Illicit/Recreational Drugs	[]	[]	[]			

Comments: []

Symptoms Since LMP: []

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INFECTION HISTORY

	Yes	No		Yes	No
1. Live with someone with TB or exposed to TB	☐	☐	5. History of STD	☐	☐
2. Patient or partner has history of genital herpes	☐	☐	Gonorrhea	☐	☐
3. Rash or viral illness since last menstrual period	☐	☐	Chlamydia	☐	☐
4. Hepatitis B, C	☐	☐	HPV	☐	☐
			HIV	☐	☐
			Syphilis	☐	☐
			6. Other (see comments)	☐	☐

GENETIC SCREENING/TERATOLOGY COUNSELING
Includes patient, baby's father, or anyone in either family with:

	Yes	No		Yes	No
1. Patients age 35 yrs. or older as of estimated date of delivery.	☐	☐	13. Huntington's Chorea	☐	☐
			14. Mental Retardation/Autism	☐	☐
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background); MCV less than 80	☐	☐	If Yes, Was Person Test for Fragile X?	☐	☐
			15. Other Inherited Genetic or Chromosomal Disorder	☐	☐
3. Neural Tube Defect (Meningomyelocele, Spina bifida or Anencephaly)	☐	☐	16. Maternal Metabolic Disorder (eg., Type 1 Diabetes, PKU)	☐	☐
4. Congenital Heart Defect	☐	☐	17. Patient or baby's father has a child with birth defects not listed above	☐	☐
5. Down Syndrome	☐	☐			
6. Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)	☐	☐	18. Recurrent Pregnancy Loss or a Stillbirth	☐	☐
7. Canavan Disease (Ashkenazi Jewish)	☐	☐	19. Medications (Including supplements, vitamins, herbs or OTC drugs, illicit/recreational drugs or alcohol since last menstrual period	☐	☐
8. Familial Dysautonomia (Ashkenazi Jewish)	☐	☐			
9. Sickle Cell Disease or Trait (African)	☐	☐			
10. Hemophilia or Other Blood Disorders	☐	☐	If Yes, Agent(s) and Strength/Dosage:[]		
11. Muscular Dystrophy	☐	☐	20. Any Other:[]		
12. Cystic Fibrosis	☐	☐			
Comments/Counseling: []					

Patient Name: Patient Name

Patient Signature: **Date:**

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Patient Name

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO		YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS/HOSPITALIZATIONS			
Reason	Date	Reason	Date

INJURIES/ILLNESSES			
Type	Date	Type	Date

LAST IMMUNIZATION OR TEST			
	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB/GYN HISTORY			
	Number		Number
Births		Abortions	
Miscarriages		Living children	

CURRENT MEDICATIONS			
Drug Name	Dosage	Drug Name	Dosage

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FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

Habits							
Smoking	Yes	☐	No	☐	Packs per day_____	Years_____	
Alcohol	Yes	☐	No	☐	Drinks per day_____	Drinks per week_____	
Drug Use	Yes	☐	No	☐			
Seat Belt Use	Yes	☐	No	☐			
Regular Exercise	Yes	☐	No	☐			

Personal Profile								
Marital Status	Married	☐	Single	☐	Widowed	☐	Divorced	☐
Number of Living Children_____								
Number of people in household_____								
School Completed	High School	☐	College	☐	Graduate Degree	☐	Other	☐
Current or most recent job_____								

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient:_____

Date reviewed by physician with patient:_____

Physician Signature:_____

Annual Review of History

Date reviewed:_____ Physician Signature:_____

Date reviewed:_____Physician Signature:_____

Date reviewed:_____Physician Signature:_____

Date reviewed:_____Physician Signature:_____

Today's Date:_____ Primary Care Physician:_____

Patient's Name: Patient Name_____ Date of Birth:_____

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NOTICE TO ALL OBSTETRICAL PATIENTS

Our office shares a call rotation for night and weekend coverage with the following Board Certified OB/GYN physicians:

- Garland Scott, M.D.
- Gary Farhat, M.D.
- Arthur Vendola, M.D.
- Michael McDonnell, D.O.

Please note your acknowledgement of receipt of the above information together with your consent below.

I have read the foregoing message, understand the same, and consent that my continued care shall be on said basis.

Patient Signature **Date**

Patient Name

Patient Printed Name

Witness Signature **Date**

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Medical Information (HIPAA) Permission

Patient Name: DOB:

Situations may arise when we are unable to reach you personally. We would like to know your wishes about giving medical information about you to others.

Please list below those who may receive medical information regarding such things as your appointments, test results, referral appointments, etc.

Name: [] **Relationship:** []

Name: [] **Relationship:** []

Name: [] **Relationship:** []

May Women First Health Services leave voice messages regarding your *appointments*?
Yes ☐ No ☐

May Women First Health Services leave voice messages regarding *test results*?
Yes ☐ No ☐

HIPPA Omnibus Notice of Privacy Practices

Revised 2013
Effective as of April 14, 2013

Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment Form

Sign_____

Printed Name_____

Date_____ Witnessed_____

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INFORMED CONSENT FOR ULTRASONOGRAPHY

Your physician has requested that you have an ultrasound of your pregnancy. This information sheet will answer several important questions about this diagnostic procedure.

What is an ultrasound and what can it show about my pregnancy?
Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe far beyond the range of hearing bounce off your uterus and your developing baby producing echoes which a computer converts into detailed images.

Is ultrasound safe?
There has been extensive evaluation of the safety of ultrasound over the course of 15 years. There is no evidence that diagnostic ultrasound causes harm to either the mother or the fetus, however, ultrasounds for entertainment or non-diagnostic purposes are not recommended.

Does a normal ultrasound prove that my baby will have no abnormalities?
While a basic sonogram will detect many abnormalities, it is not definitive for fetal malformations. Despite a normal interpretation of the test, some babies will be born with anomalies not identified by the examiner during the study.

You should realize that even with a complete sonogram, the examiner may still be unable to find abnormalities that are later discovered after birth. Thus, although ultrasonography is a very helpful diagnostic tool, it should not be considered as absolute proof of the absence of fetal defects.

TYPES OF EXAMS:

- A basic or standard sonogram provides information concerning placenta location, fetal position, twin or multiple pregnancies, gestational age and presence of fetal abnormalities.
- A vaginal sonogram, in which a special ultrasound instrument, about the thickness of a tampon, is inserted into the vagina, is occasionally used to provide extremely detailed views of the uterus, ovaries or portions of the fetus that are low in the pelvis. This may be used to see the heartbeat or the location of a very early pregnancy, or to evaluate the placenta or birth canal. As with other ultrasound exams, the procedure is safe.

CONSENT:
Should you have any questions concerning ultrasonography, do not hesitate to discuss them with your health care provider or the sonographer before undergoing the procedure. You are expected to sign this document prior to the performance of your ultrasound examination and/or video to thereby acknowledge that you have read and understand the information contained herein, and have given informed consent to this procedure.

X: [] _____ Date: Report Date

Patient Signature

X: [] _____ Date: Report Date

Witness

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Thank you for choosing Women First Health Services for your obstetrical care. Ensuring quality care for you and your baby is our top priority. Your first visit will be with a Certified Nurse Midwife. The nurse midwife will be asking some questions concerning the medial history of you and the baby's father. Please take some time with both families to go over the following:

History pertaining to <u>YOU & Your Family</u>	**YOU**	**Your Family**
• Allergies	☐	☐
• Phlebitis (blood clots)	☐	☐
• Varicosities (varicose veins)	☐	☐
• DVT (deep vein thrombosis)	☐	☐
• Transfusions	☐	☐
• Operations	☐	☐
• Urinary tract infections / Kidney disease	☐	☐
• Diabetes	☐	☐
• Thyroid Disease	☐	☐
• Seizures	☐	☐
• Migraines	☐	☐
• Anemia or Bleeding tendencies	☐	☐
• Rheumatologic Disease including Lupus	☐	☐
• Depression or any psychiatric illness	☐	☐
• Cancer	☐	☐
• Breast Disease	☐	☐
• Multiple births	☐	☐
• Hypertension	☐	☐

History pertaining to <u>FATHER OF BABY</u>	(Check if applicable)
• Tuberculosis	☐
• Heart Disease or Heart Attacks	☐
• Birth Defects	☐
• Genetic disorders	☐
• Cleft Lip/Palate	☐
• Mental Retardation	☐
• Other	☐

Knowing these genetic predispositions can help anticipate some of the areas that may need careful observation so that the health of you and your baby are not compromised. Thank you for your time and efforts. We look forward to meeting you.

Patient Name Date of Birth

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OVER THE COUNTER MEDICATIONS YOU MAY TAKE WHILE YOU ARE PREGNANT

PAIN & FEVER:
Tylenol (regular or extra strength)

HEARTBURN & GAS:
Maalox
Mylanta
Tums
Rolaids
Riopan (low sodium)
Zantac
Pepcid AC
Myelocon

SORE THROAT:
Gargle with warm salt water

SLEEP:
Tylenol PM
Unison

HEMORRHOIDS:
Anusol (HC or regular)
Tucks
Chamomile Extract (in sitz baths)

MINOR SKIN RASHES:
Calamine Lotion
Vitamin E Ointment
5% Hydrocortisone Cream (do NOT exceed 7 days)
Lanolin
A&D Ointment

YEAST INFECTIONS:
Monistat
Vagisil

HEAD LICE:
Nix 1%
RID

COLDS:
Sudafed
Robitussin (regular)
Tylenol Cold (NOT multisymptom)
Tylenol Sinus
Claritin & Claritin D
Allegra & Allegra D
Benadryl
Actifed
Dimetapp

DIARRHEA:
Kayopectate
Imodium AD

NAUSEA & VOMITING:
Emetrol (**NOT for use by diabetics**)
Vitamin B (50mg 1-3 times/day)
Peppermint

RINGWORM:
Tinactin (cream or lotion)

STOOL SOFTNERS AND LAXATIVES: Colace, Milk of Magnesia, Metamucil, Fibercon, Prunes / Prune Juice, Increase water & fiber intake

Extra Vitamin C is beneficial in pregnancy and throughout your life. It boosts your immune system and helps you use the iron in plant foods. 250 mg 2-3 time a day is a good dosage to use.

IMMEDIATELY REPORT ALL FEVERS OF 100.5 DEGREES OR MORE.

IF THE CONDITION THAT YOU ARE TREATING WITH OVER THE COUNTER MEDICATIONS DOES NOT GO AWAY WITHIN A FEW DAYS, PLEASE CONTACT US AT 517.787.6838.

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IS IT SAFE TO SMOKE DURING PREGNANCY?

NO!

Apart from smoking's well-known dangers to anyone, such as increased risk for heart disease and cancer, women who smoke during pregnancy are at greater risk for giving birth to low-birth weight babies. On average, babies born to women who smoked during pregnancy are almost **half a pound lighter than women who don't smoke. Low birth weight is one of the leading causes of infant illness, disability and death.**

Other problems with well-documented associations with smoking include **ectopic pregnancy (where the fertilized egg implants outside the womb), miscarriage, abnormal placental implantation, premature placental detachment (abruption), vaginal bleeding, premature delivery and infant death.**

Some studies have shown that smoking during pregnancy **may hurt the child's mental development and behavior, leading to a short attention span and hyperactivity.** Other research shows that certain birth defects may show up more in babies whose mother smoked during the pregnancy. For example, one study performed by the California Birth Defects Monitoring Program showed that mother who smokes 20 or more cigarettes per day were **more than twice as likely to have babies born with a cleft lip and / or palate if they were genetically predisposed and if their mother smoked.**

Finally, the further into pregnancy a woman smokes, the greater the risk of complication. For example, if a pregnant woman stops smoking during the first half of her pregnancy, her baby most likely will be a normal weight at birth. If she continues to smoke throughout her pregnancy, she'll probably have a low-birth weight baby. So if you're a smoker and have not succeeded in quitting so far, stopping now, or at the very least cutting down on the number of cigarettes you smoke a day, can still benefit you and your baby.

Infant of smokers also have a higher risk of developing respiratory infections, asthma and have a higher rate of **Sudden Infant Death Syndrome.**

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Commonly Asked Questions in Pregnancy

Medications

During pregnancy it is best to avoid the use of medications if possible. However, discomforts may occur during pregnancy necessitation medication. Not all over the counter medications can be used in pregnancy. We have compiled the following list of medications which you may use, ***AFTER YOU HAVE COMPLETED YOUR FIRST TRIMESTER***. If a medication is not included it should not be taken unless the physician approves it.

Colds / Congestion / Allergies:

You may want to try some non-medicinal remedies for the discomforts of a cold / stuffy nose. Obviously, as with any illness, extra rest is needed along with increased intake of fluids. You may benefit from extra moisture in the air from a vaporizer. Drinking hot tea or broth may help open nasal passages as well as provide fluid. A sore throat or cough may be relieved with throat lozenges or cough drops.

If these measures do not provide enough relief you may try one of the following over the counter medications, ***AFTER YOU HAVE COMPLETED YOUR FIRST TRIMESTER.***

- Afrin, Allerest, Benadryl, Chlor-Trimeton, Cold Control+, Contac, Coricidin (Plain Only), Dristan Cold & Flu, Drixoral (Non-Drowsy Formula), Medi-Flu & Medi-Flu w/out Drowsiness, Novahistine DMX, OMES (Reg or Maximum Strength), Sine-Off, Singlet, Sinutab, Sudafed, Teldrin, Theraflu, Tylenol and Vick's Products

If you develop a fever or other symptoms of infection you need to call your primary care provider or our office.

Cough

Benylin, Cheralcol-D, Robitussin, Dimetapp and Vick Formula 44

Body Aches / Pain

You may obtain significant relief from rest and a soothing bath or shower. If greater relief is needed you may try any of the following brands of acetaminophen: Datril, Panadol, Tylenol or any generic or store brand acetaminophen.

Nausea and/or Vomiting

Eating small amounts of food frequently, avoiding fatty and spicy foods, and taking fluids separately from meals to avoid over filling the stomach may alleviate this common complaint of pregnancy. Often starchy foods such as crackers, breads, pasta and rice help settle the stomach. Herbal teas such as chamomile ginger or pregnancy tea may also provide relief from nausea. If these measures do not provide enough relief you may try any of the medications listed below.

- Bonine, Dramamine, Emetrol Marazine and Unisom

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Heartburn

Heartburn may be relieved by eating small portions frequently rather than 3 large meals daily. Do not drink a lot of fluid with your meals. You should also avoid lying down immediately after eating. Spicy foods or those containing caffeine may cause more discomfort and may need to be avoided. If heartburn is a problem after these measures you may try the following antacids.

- Gaviscon, Gelusil, Maalox, Mylanta, Riopan, Rolaids and Tums

Constipation

Constipation may be avoided by eating a diet rich in fresh fruits and vegetables and whole grains along with plenty of fluids. The best natural laxative is often prunes or prune juice. You may also try any of the following bulk laxatives.

- Citrucel, Colace, Dialose, Dulcolax, Fiberall, Fibercon, Surfak and Metamucil

Hemorrhoids

Prevention of constipation is one way of preventing hemorrhoids. Despite these efforts some women will develop hemorrhoids in pregnancy. The following remedies may provide relief in this event.

- Americaine Ointment, Anusol Cream, Nupercainal, Preparation H, Tronolane and Tucks Pads or Cream

Exercise

Another common question of pregnant women is “can I exercise”? If you do not have restrictions for other medical conditions and if you do not have complications in your pregnancy, you may continue to engage in exercise to which you are accustomed. During exercise you should monitor your heart rate to assure that is remains below 140 beats per minute. Never exercise to the point of exhaustion or allow yourself to become overheated. As your body changes in shape you may need to modify your exercise to accommodate your stretched abdominal muscles and changes you will experience in your sense of balance.

If you do not regularly engage in exercise but wish to begin during your pregnancy you may try walking, swimming, low impact aerobics, or exercise videos intended for use in pregnancy. Remember to monitor your heart rate and do not overdo. It is also important to avoid overheating in a sauna or hot tub during pregnancy.

Please keep this as a reference throughout your pregnancy and do not hesitate to call our office with any questions.

R.A. Pastoriza, M.D.

Laura McCully, C.N.M., M.S.

www.womenfirsthealth.com

Women first health services

1100 east michigan avenue
suite 205
jackson, michigan 49201
phone 517.787.6838
fax 517.787.5623

LAB WORK

Please notify us of any special instructions that you may have for your **LAB WORK**. As a general rule, most lab work is sent to Allegiance Hospital. If you or your insurance company require your lab work to be sent to any other location, it is necessary to inform us **PRIOR** to labs being sent out.

We are not responsible for labs being sent to the wrong location, If not specified at the time of service.

Patient Name _____

Patient Signature: _____ Date: _____

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The Health of You and Your Baby is Important to Us…….

So please take a moment to answer the following questions. We ask all of our patients about these issues because they are so common and important. Your answers to all of the following questions will be kept confidential.

	Yes	No
1. In the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone?	☐	☐
2. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	☐	☐
3. Within the last year, has anyone made you do something sexual that you didn't want to do?	☐	☐
4. Are you afraid of your partner or anyone else?	☐	☐
5. During the past month, have you often been bothered by feeling down, depressed, or hopeless?	☐	☐
6. During the past month, have you often been bothered by little interest or pleasure in doing things?	☐	☐
7. Did either of your parents ever have a problem with alcohol or other drug use?	☐	☐
8. Do any of your friends have problems with alcohol or other drug use?	☐	☐
9. Does your partner have a problem with alcohol or other drug use?	☐	☐
10. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	☐	☐
11. In the past, have you drunk any beer, wine, or liquor or used other drugs?	☐	☐

Which statement best describes your current smoking status:

☐ I have never smoked or have smoked fewer than 100 cigarettes in my lifetime.
☐ I stopped smoking before I found out I was pregnant, and I am not smoking now.
☐ I stopped smoking after I found out I was pregnant, and I am not smoking now.
☐ I smoke some now, but I have cut down on the number of cigarettes that I smoke since finding out that I was pregnant.
☐ I smoke regularly now, about the same as before I found out I was pregnant.

Last Name_____First Name_____Middle_____

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Patient Signature_____Date _____

Address_____

_____

Date of Birth_____Phone_____Other Phone Numbers_____

Name of Dr. for this pregnancy_____Due Date_____

	YES	NO
1. Need for Childbirth education		
Do you know what to expect at different stages of your pregnancy?	☐	☐
Would you like to learn more about Delivery?	☐	☐
Do you have experience in caring for a baby?	☐	☐
Would you like to learn more about how to take care of your baby?	☐	☐
2. Need for transportation to keep medical appointments?	☐	☐

How do you get around? Car ☐ Public Transport ☐

How do you plan to get to medical appointments?_____

3. Need for assistance to care for your infant?

Are you good at following instructions? yes☐ no☐

Barriers: Language ☐ Literacy ☐ Education level_____

Physical imitations_____

Describe where you live: Rent☐ Own home☐ Shelter☐ Motel

Family ☐ In your car☐

4. Nutrition/Health Problems

Describe your eating habits: Number of meals eaten per day_____

Skip Meals ☐ Fast Food ☐ Cook at Home ☐

Which beverages do you drink? Pop ☐ Juice ☐ Water ☐ Milk ☐

Do you have any non-food cravings, e.g. PICA? yes☐ no☐

Is your blood or iron low (anemia?) yes☐ no☐

Do you have high blood pressure? yes☐ no☐

Do you have diabetes now or during other pregnancies? yes☐ no☐

Have you had problems with weight gain/loss during your pregnancy? yes☐ no☐

Do you have any other health problems that concern you? yes☐ no☐

5. Family support

Are you under 18 years old? yes☐ no☐ Who do you live with_____

Who supported you during pregnancy?_____

Who can you count on for support from? The baby's father? yes☐ no☐

Your parents? yes☐ no☐ A friend?yes☐ no☐

Anyone else?_____

6. Feelings about current pregnancy

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Have you been pregnant before? yes☐ no☐

What are your feelings about this pregnancy? happy ☐ unhappy☐ don't know☐

Did your last pregnancy result in fetal (womb) or neonatal (within 30 days of birth) death? yes☐ no

☐ Have you experienced death of a prior child before the age of one? yes☐ no☐

7. Mother with cognitive, emotional mental needs

How are you coping with taking care of your baby? good☐ bad☐ ok☐

Do you feel stressed? yes☐ no☐

Do you have a history of postpartum depression? yes☐ no☐

Do you have any concerns about your mental or emotional health? yes☐ no☐

8. Social situation

Do you worry about somebody mistreating you? yes☐ no☐

Do you worry about anyone mistreating your children/grandchildren? yes☐ no☐

Are you planning on moving during your pregnancy? yes☐ no☐

9. Use of alcohol, drugs or tobacco products:

Do you smoke? yes☐ no☐ Do you use street drugs? yes☐ no☐

Do you drink alcohol (beer, wine, liquor) now that you are pregnant? yes☐ no☐

10. Other

_____

_____

Medical or MSS Care Provider

Signature_____Date:_____

Print Name:_____

PROVIDER ONLY:

Fax Completed Form Renee Marks 517-768-1640