The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Patient Addressograph

ANTEPARTUM RECORD

Date: – – ID #:

Hospital of Delivery:

Name:

LAST FIRST MIDDLE

Newborn Care Provider:	Referred By:
Primary Care Provider/Group:	Address:
Final EDD:	
Birth Date: – – Age: Race: Marital Status: S M W D Sep	Address: / Zip: Phone: (1) (2)
Occupation: Education: (Last Grade Completed)	E-Mail:
Language: Ethnicity:	Insurance Carrier/Medicaid #:
Partner: Phone:	Policy #:
Father Of Baby: Phone:	Emergency Contact: Phone:

Total Preg:	Full Term:	Premature:	Ab, Induced:	Ab, Spontaneous:	Ectopic Pregnancy:	Multiple Births:	Living:

Menstrual History

Lmp ☐ Definite ☐ Approximate (Month Known)
☐ Unknown ☐ Normal Amount/Duration
☐ Final: ___________

Duration: Q ________ Days
Prior Menses: ________ Date

Frequency: Q ________ Days
Contraception at pregnancy ☐ Yes ☐ No

Menarche: ______________ (Age Onset)
Hcg + ____/____/____

Past Pregnancies (Last Five)

Date Month/ Year	GA Weeks	Length Of Labor	Birth Weight	Sex M/F	Type Of Delivery	Anes	Place Of Delivery	Breastfeeding Duration	Lactation Consult Needed Yes/No	Comments/ Complications

Medical History

	P*	F*	Detail Positive Remarks Include Date & Treatment
A. Drug/Latex Allergies/ Reactions			
B. Allergies (Food, Seasonal, Environmental)			
1. Neurologic/Epilepsy			
2. Thyroid Dysfunction			
3. Breast Disease/Breast Surgery			
4. Pulmonary (TB, Asthma)			
5. Heart Disease			
6. Hypertension			
7. Cancer			
8. Hematologic Disorders			
9. Anemia			
10. Gastrointestinal Disorders			
11. Hepatitis/Liver Disease			
12. Kidney Disease/UTI			
13. Deep Vein Thrombosis			
14. Diabetes (Type 1 Or Type 2)			
15. Gestational Diabetes			
16. Autoimmune Disorders			

	P*	F*	Detail Positive Remarks Include Date & Treatment		
17. Dermatologic Disorders					
18. Operations/Hospitalizations (Year & Reason)					
19. Gyn Surgery (Year & Reason)					
20. Anesthetic Complications					
21. History Of Blood Transfusions					
22. Infertility					
23. Art (IVF Or FET)					
24. History of Abnormal Pap					
25. History of STI					
26. Psychiatric Illness					
27. Depression/Postpartum Depression					
28. Trauma/Violence			Prepreg	Preg	# Years Use
29. Tobacco (Smoked, Chewed, ENDS, Vaped) (AMT/Day)					
30. Alcohol (AMT/Wk)					
31. Drug Use (Including Opioids) (Uses/Wk)					
32. Polycystic Ovary Syndrome					
33. Other					

*P= Personal, F= Family

COMMENTS: ____________________

Version 8.1 (December 2017) Copyright 2017 The American College of Obstetricians and Gynecologists

Patient Name:		Birth Date: – –	ID No.:	Date: – –

Genetic Screening*				
Condition	**Patient**	**Partner**	**Other**	**Relationship**
Congenital Heart Defect				
Neural Tube Defect				
Hemoglobinopathy Or Carrier				
Cystic Fibrosis				
Chromosome Abnormality				
Tay–Sachs				
Hemophilia				
Intellectual Disability/Autism				
Recurrent Pregnancy Loss/Stillbirth				
Other Structural Birth Defect				
Other Genetic Disease (eg, PKU, Metabolic Disease, Muscular Dystrophy)				

Teratogen Exposures Since LMP/Pregnancy	Yes	No	Details/Date
Prescription Medications			
Over The Counter Medications			
Alcohol			
Illicit Drugs			
Maternal Diabetes			HGB A1C
Other			
Uterine Anomaly/DES			

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: ______________________________

Infection History	Yes	No		Yes	No
1. Live with Someone with TB or Exposed to TB			6. HIV Infection		
2. Patient or Partner Has History of Genital Herpes			7. History Of Hepatitis		
3. Rash or Viral Illness Since Last Menstrual Period			8. Recent Travel History or Partner Travel Outside of Country		
4. Prior GBS-Infected Child			9. Recent Exposure to Zika Virus, Including by Partner. Assess at each prenatal visit. Check cdc.gov/zika for updates.		
5. History of STIs: (Check All That Apply) ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ PID			10. Other (See Comments)		

COMMENTS: ______________________________

______________________________ INTERVIEWER'S SIGNATURE: ______________________________

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*	Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Tdap (Each pregnancy; as early in the 27–36-weeks-of-gestation window as possible)				Hepatitis A (When Indicated)			
Influenza† (Each pregnancy as soon as vaccine is available)				Hepatitis B (When Indicated)			
Varicella†				Meningococcal (When Indicated)			
MMR (Rubella-containing vaccine)†				Pneumococcal (When Indicated)			
HPV							

*Yes/No and date to be administered

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the HPV, MMR, and varicella vaccines postpartum if needed. The Tdap vaccine can be given postpartum if the woman has never received it as an adult and did not get it during pregnancy.

Version 8.1 (December 2017) Copyright 2017 The American College of Obstetricians and Gynecologists

The Women's Health Institute™

Consent – OB STD Testing

10131 Forest Hill Blvd, Suite 130 • Wellington, FL 33414 • 561.784.1933 • fax: 561.784.5109 • TheWHI.com

The CDC as well as the physicians in this office strongly recommended an HIV test for all pregnant women. The test is voluntary. There are two reasons to be tested: (1) New medications are available to reduce the chance of an infected mother passing HIV to her baby; and (2) Most women do not know they are infected with HIV until later in the disease. Sometimes, other infections can put you and your baby at risk.

Section 381.004 of the *Florida Statues* and Chapter 64D-3.042 of the *Florida Administrative Code* require that healthcare providers:

- Conduct routine testing for HIV, Chlamydia, gonorrhea, syphilis, hepatitis B, genital herpes, and genital human papilloma virus on **all** pregnant women, using the opt-out (signed consent not required) approach, at the first prenatal visit and again at 28-32 weeks gestation.
- Test women in labor who have no record of an HIV test after 27 weeks gestation. They are considered high risk for sexually transmitted diseases and must be tested for all of the above STDs prior to discharge.
- Document on the birth certificate if chlamydia, gonorrhea, hepatitis B, HIV, syphilis infections or genital herpes or genital human papilloma virus were present and/or treated during the pregnancy.

In addition, we may also test for Trichomoniasis and other STDs.

One in five babies born infected with HIV in Florida since 2000 has been born to a mother with an initial negative HIV test.

The human immunodeficiency virus (HIV) antibody test detects antibodies to HIV. These antibodies are made by the body after infection with HIV, the virus that can cause Acquired Immune Deficiency Syndrome (AIDS). It can take up to six months for these antibodies to develop. This is called the window period. During this time, you can test negative for HIV even though the virus is in your body and you can give it to others. A positive HIV test means that you are infected with HIV and can give it to others even when you feel healthy.

If you test positive for HIV, you will be asked about sex or needle-sharing partners or if you have been married at any time within the past 10 years. If so, you will be informed of the importance of notifying your spouse or former spouse(s) or other partner(s) of the potential exposure to HIV. You will be offered the assistance of public health personnel in notifying your partner(s). If you test positive, your name will be given to the local county health department so that you may be offered case management services and voluntary partner notification. If you are pregnant, there is treatment available to help prevent your unborn baby from getting HIV.

People with HIV infection are very likely to develop AIDS over many years. Finding HIV infection early can be important to your treatment. If you have any questions, please ask your counselor, physician, or call the Florida AIDS Hotline (1-800-FLA AIDS) before signing this form.

This test is taken voluntarily. If you choose not to take the test, you will not lose any service(s) to which you are entitled. The HIV test result will become part of your confidential medical record. (If you are pregnant, or you become pregnant, the results of the test will also become part of your baby's medical record.)

A specimen will be taken and sent to the laboratory for testing, with the test results available in approximately 1 week. Test results are highly reliable but do not guarantee you are healthy. If you want to be retested, you should talk to your counselor or physician. The test result will only be given to you in person. No results will be given over the telephone or by mail.

PATIENT CERTIFICATION:
By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form. I understand the information on this form and what has been explained to me. I understand that there is no guarantee of outcome.

On the basis of the above statements,

☐ I have read and understand the above and consent. I understand and accept the consequences of this decision.

☐ I have read and understand the above and do NOT consent. I understand and accept the consequences of this decision.

____ ____________________
SIGNATURE OF PATIENT / PATIENT REPRESENTATIVE DATE

☐ Patient refused to sign this document

©2004, The Women's Health Institute, LLC