Lakewood Ranch Medical Group

Congratulations on your pregnancy! If you have any questions about completing this form, please ask your nurse.

DATE: _____

Name: _____ Age: _____ DOB: _____ Ht: _____ Pre-pregnancy Wt: _____

Marital Status: S M D Engaged Father of Baby's Name: _____

If employed, what is your occupation? _____

Have you had any problems with this pregnancy so far? _____

Have you had any emergency care, labs, or ultrasounds prior to this visit? _____ If Yes, when and where?

_____

Who will be this baby's doctor/pediatrician? _____

Do you know the exact day of your last period STARTED?	Yes or No
If YES, what is the date of the FIRST DAY of your last period?	
Have your periods started consistently every 21-35 days for the 3 cycles prior to your last period?	Yes or No
If NO, how frequent are your cycles?	
Did you get pregnant while using birth control? If so, what type?	Yes or No
What was the date of your 1st positive pregnancy test?	

ALL Past Pregnancies

In order for us to provide you the very best care, please include this pregnancy, terminations, miscarriages or stillbirths

Mo/Day/Year	Weeks Gestation	Birth Weight	Gender M/F	Vaginal or C-Section	Anesthesia: none, epidural, spinal, general	Complications: Preterm labor, high blood pressure, diabetes, depression, rapid labor, etc.

Please list any medications, vitamins or supplements you have used <u>since your last period</u> And place a checkmark if you are currently taking or have stopped the medication	Currently Taking	Stopped

Please list any drug allergies and reaction if known: _____

Please indicate if you, the baby's father, or any family members have any of the following conditions:	**YES**	**NO**
Will you be 35 or older when this baby is due?		
If you or your partner is of Asian or Mediterranean decent, is there a history of Thalassemia?		
Is there a family history of Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)?		
Is there a family history of birth defects of the heart?		
Is there a family history of Down syndrome?		
If you or your partner is of eastern European, Jewish, or French-Canadian descent, is there a history of Tay-Sach's disease or Canavan disease?		
If you or your partner is African American, is there a history of sickle cell disease or trait?		
Is there a family history of hemophilia or bleeding disorders?		
Is there a family history of muscular dystrophy?		
Is there a family history of cystic fibrosis lung disease?		
Is there a family history of Huntington Chorea?		
Is there a family history of mental retardation or autism?		
If so, was this person tested for fragile X syndrome?		
Is there a family history of any other genetic diseases, chromosomal disorders, or birth defects?		
Do you have a metabolic disorder such as diabetes, thyroid disease, or phenylketonuria?		
Have you ever had a positive TB skin test, been treated for Tuberculosis, or lived with someone with TB?		
Do you or your partner have genital herpes?		
Have you had an illness, fever, or rash since your last period?		
Have you ever had a sexually transmitted disease such as gonorrhea, chlamydia, syphilis, or HPV?		
If YES, please circle which and indicate year infection was treated.		
Have you had chicken pox? Yes ____ No ____ Have you had the vaccine? Yes ____ No ____		
Have you had fifth's disease (Parvo B19)?		
Have you ever been diagnosed with HIV?		
Have you ever been diagnosed with hepatitis?		
Have you given birth to a child who was later diagnosed with GBS-infection?		
Do you own a cat?		
Have you ever had problems with anesthesia?		
Do you wear a seatbelt?		
Do you exercise regularly?		
Do you drink caffeinated beverages? Yes ___ No ___ If so, how many per day? _____		
Did any of your parents have a problem with alcohol or other drug use?		
Do any of your friends have a problem with alcohol or other drug use?		
Does your partner have a problem with alcohol or other drug use?		
Are you feeling at all unsafe in any way in your relationship with your current partner?		
Over the last few weeks has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home?		
In the past have you had difficulties in your life due to alcohol or other drugs, including prescription medications?		
Have you had any alcohol or used any other drugs since your last period?		
How many days per month do you drink? _____How many drinks on any given day? _____		
Smoking: (check one) Current smoker ____ How many per day? _____ For how many years? _____		
Former smoker ____ Date of last use? _____		
Never a smoker _____		
Do you use e-cigarettes/vape? No ____ Yes ____ With Nicotine _____ Without Nicotine _____		
Are you planning to breastfeed your baby? No ___ Yes ____		
If you plan to use contraception after delivery to prevent pregnancy, which type are you considering? IUD ____ Nexplanon ____ DepoProvera _____ Pill ____ Other _____		

Lakewood Ranch Medical Group

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____

I am requesting disclosure of my protected health information for the following purpose:

- ☐ Continuing Care
- ☐ Disability Determination
- ☐ Legal Investigation
- ☐ Other: _____

I **authorize the release of the following:**

- ☐ Provider office note
- ☐ Lab results
- ☐ Diagnostic Reports
- ☐ Other: _____

Items below will not be included unless checked:

- ☐ Psychological Evaluation
- ☐ Alcohol and Drug Abuse Treatment Records
- ☐ HIV Test Results and AIDS Treatment Records

Obtain my health information from:

☐ _____ (____)_____ _____
Facility/Provider's Name Telephone or Fax Number Address City State Zip Code

Release my health information to:

☐ _____ (____)_____ _____
Facility/Provider's Name Telephone or Fax Number Address City State Zip Code

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire one year from signature date)

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

This form must be completed in full before signing:

_____ _____ _____
Patient's signature (required for ages 12 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness signature Date Signed

This authorization is intended to allow The Pavilion to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the STATE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. ***FACILITY*** is not liable for such re-disclosures.