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Dear Patient:

Congratulations on your pregnancy. The attached forms are important information for your first prenatal visit. Please complete them and bring them to your first appointment. If you do not bring them, you will have to fill them out again which would affect your appointment time.

On page 1, please fill out the following:

1. All marked areas
2. Obstetrical Screening
3. Read Drugs, Alcohol, and Smoking counseling sheet and sign form.
4. Please note: last menstrual period. We need the first day of your last period where it says LMP.

You must arrive 30 minutes before your appointment time. Failure to do so may result in rescheduling or delaying your appointment time.

If you have any questions, please feel free to call the office. We look forward to caring for you and your baby during your pregnancy!

Sincerely,

Genesis Ob/Gyn, Inc.

DePaul Health Center  
Medical Office Bldg. East  
12266 DePaul Drive  
Suite 200  
Bridgeton, MO 63044  
Phone: 314-291-2975  
Fax: 314-291-2783

5/10



Patient Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Religion \_\_\_\_\_  
 Heritage/Ethnicity \_\_\_\_\_ Marital Status: S M SEP D W  
 Name of Baby's Father \_\_\_\_\_

	Education	Occupation	Home Phone	Work Phone	Cell Phone	Pager
Patient						
Father of Baby						

Primary Physician \_\_\_\_\_ Emergency Contact: (Relationship) \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ Name: \_\_\_\_\_  
 Gr \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ A \_\_\_\_\_ L \_\_\_\_\_  
 LMP: \_\_\_\_\_ PMP \_\_\_\_\_ EDC \_\_\_\_\_

**Medication Allergy / Sensitivity** None  
 (Identify) \_\_\_\_\_  
 \_\_\_\_\_

Meds Prescribed	Start Date	Stop Date	Start Date	Stop Date
1. _____			4. _____	
2. _____			5. _____	
3. _____			6. _____	

**SURGERIES**  
 \_\_\_\_\_  
 \_\_\_\_\_

**SIGNIFICANT MEDICAL HISTORY**  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY** (Check All That Apply)

Genetic Disorders       Bleeding Disorder  
 Twins/Multiples       Blood Clots in Legs or Lungs  
 Diabetes                   Hypertension

**SOCIAL HISTORY**

Tobacco Use  
 Alcohol Use  
 Drug Use

\_\_\_\_\_ Name \_\_\_\_\_

**INITIAL PHYSICAL EXAMINATION**

	normal	abnormal
HEENT .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid.....	<input type="checkbox"/>	<input type="checkbox"/>
Lungs .....	<input type="checkbox"/>	<input type="checkbox"/>
Breasts .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart .....	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen .....	<input type="checkbox"/>	<input type="checkbox"/>
Ext. Genitalia .....	<input type="checkbox"/>	<input type="checkbox"/>
Vagina.....	<input type="checkbox"/>	<input type="checkbox"/>
Cervix .....	<input type="checkbox"/>	<input type="checkbox"/>
Uterus.....	<input type="checkbox"/>	<input type="checkbox"/>
Adnexa .....	<input type="checkbox"/>	<input type="checkbox"/>
Rectum .....	<input type="checkbox"/>	<input type="checkbox"/>
Other .....	<input type="checkbox"/>	<input type="checkbox"/>

Exam done on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 by: \_\_\_\_\_

	Month / Year	Infant's Sex	Birth Weight	Weeks Gestation	Hours in Labor	Type of Delivery	Anesthesia	Preterm Labor	Comments / Complications
1									
2									
3									
4									
5									
6									
7									
8									

# OBSTETRIC SCREENING QUESTIONNAIRE

Name _____	<u>YES</u>	<u>NO</u>
1. Will you be age 35 or older when you deliver? .....	_____	_____
2. Have you had 3 or more spontaneous pregnancy losses (miscarriages, stillbirths, etc)? .....	_____	_____
3. Have you or your partner or anyone in either of your families had:		
a. Down Syndrome (mongolism)? .....	_____	_____
b. Spina bifida or meningomyelocele (open spine)? .....	_____	_____
c. Hemophilia or other blood clotting problem? .....	_____	_____
d. Muscular Dystrophy? .....	_____	_____
e. Cystic Fibrosis? .....	_____	_____
f. Mental Retardation? .....	_____	_____
4. Have you or your partner or anyone in either of your families had a child born with a defect not listed in Question 3 above? .....	_____	_____
5. Do you or your partner have any close relatives who have any inherited genetic or chromosomal disease or disorder not listed above? .....	_____	_____
6. Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)? .....	_____	_____
7. Do you or your partner have any close relatives from Mediterranean or Asian countries? .....	_____	_____
If yes, have you or your partner been screened for thalassemia? .....	_____	_____
If yes, what were the results? _____		
8. If you or your partner is black, have you been screened for Sickle Cell? .....	_____	_____
9. Have you ever been diagnosed or treated for depression or post partum depression? .....	_____	_____
10. Were you born between the years 1957 - 1980? .....	_____	_____
If so, have you been re-vaccinated for the measles or tested for immunity? .....	_____	_____
11. Have you been vaccinated for the following?		
Rubella _____ Measles _____ Mumps _____ Chicken Pox _____		
12. Have you been exposed to Tuberculosis? .....	_____	_____
13. Do you have a family or personal history of blood clots in the legs or lungs? .....	_____	_____
14. Do you drink alcoholic beverages? .....	_____	_____
If yes, describe how often and how much _____		
15. Do you smoke cigarettes? .....	_____	_____
If yes, describe how often and how much _____		
16. Have you ever used street drugs? .....	_____	_____
If so, what have you used and when? _____		
If so, have you ever used needles? .....	_____	_____
17. Have you taken any medications either by prescription or those which can be purchased over the counter in a drug store, including supplements, vitamins, herbs, recreational drugs or alcohol since your last menstrual period? .....	_____	_____
18. Do you have any objections to receiving blood products in a life-threatening situation? (i.e.: would you want us to allow you to die rather than give you blood)? .....	_____	_____
19. Have you been intimate with anyone with AIDS, anyone who has homosexual or bisexual, or anyone who used drugs with needles? .....	_____	_____
20. Do you have or have you been exposed to anyone with herpes, blisters, vesicles, sores or other lesions on their genitals? .....	_____	_____

Signature \_\_\_\_\_

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## ***Avoid Drugs, Cigarettes and Alcohol***

Almost anything that enters your body affects the baby in some way. Early fetal development is rapid, complex and very sensitive to outside influences. It is important for you to know about the effects of drugs, smoking and alcohol on your baby's growth and development.

### **DRUGS**

It is important to avoid ALL types of medications, unless they have been recommended by your health care provider.

When you take any drugs or medications, no matter how common, the baby gets a dose too. How this dose affects the baby is unclear. However, its tiny immature body may not react to the drug as your body does. As studies continue, we are discovering which drugs may cause birth defects if taken during your pregnancy. However, much more work in this area is needed. Play it safe; don't take any medication or drugs unless you have talked to your health care provider first.

If you use cocaine, this is likely to interfere with your unborn baby's oxygen supply. In addition, cocaine has been linked to premature separation of the placenta, which may cause premature birth, birth defects, cerebral palsy or even death.

### **SMOKING**

Cigarette smoke contains many harmful poisons, including nicotine and carbon monoxide. Nicotine narrows the blood vessels that carry blood and oxygen to the baby, so the baby gets less oxygen and nutrients for growth and development. Carbon monoxide, carried by the blood, forces oxygen out of the red blood cells. Consequently, instead of the blood carrying oxygen to your baby, it is carrying carbon monoxide.

\* Babies born to mothers who smoke during pregnancy are more likely to be smaller.

\* Studies show that women who smoke have a greater chance of stillbirths, spontaneous abortions, and premature deliveries than women who don't smoke.

If you don't smoke - don't start! If you do smoke, try to quit or at least cut down during your pregnancy. Remember, every breath you take is shared with your baby.

### **ALCOHOL**

Alcohol crosses the placenta and enters the baby's blood system in the same concentration as in your blood. A pregnant woman who drinks heavily risks having a baby with birth defects. Children of alcoholic women are at risk for Fetal Alcohol Syndrome (FAS), a specific pattern of physical and mental defects.

Women who drink less frequently can cause some of the FAS characteristics in their babies. It is not known how many drinks are safe, if any. Therefore, if you're pregnant, avoid all alcohol. Think before you take that drink.

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**CONSENT TO TEST FOR ANTIBODIES TO THE HUMAN IMMUNODEFICIENCY VIRUS**

I, \_\_\_\_\_, after consultation with Dr. \_\_\_\_\_, do hereby give permission to \_\_\_\_\_ Lab to test my blood for the presence of antibodies to the Human Immunodeficiency Virus (HIV). The HIV Virus is associated with and is the probable cause of Acquired Immune Deficiency Syndrome (AIDS).

I understand my blood will be tested for the presence of antibodies of the HIV Virus and that a physician will discuss the results with me.

I understand that positive results do not conclusively indicate that the AIDS Virus is now in my blood. In addition, it does not mean that I definitely have AIDS nor does it predict whether or not I will develop AIDS in the future.

I further understand if the result is positive, that my attending physician and the Missouri Department of Health will be notified and that the positive test(s) could have undesirable personal, social, economic, psychological, and insurability consequences to me.

I have been given the opportunity to ask questions which have been answered to my satisfaction. I have read the above and have had the opportunity to discuss this information and my questions with the above named Doctor.

I am aware of the tests limitations and the potential consequences of positive and negative test results. My signature indicates that I give my informed consent to have the screening test(s) performed on the sample of my blood.

\_\_\_\_\_  
(patient name) (witness) (date)

If the patient is a minor or is unable to sign, complete the following:

The patient (is a minor \_\_\_\_\_ years of age) or is unable to sign because \_\_\_\_\_

\_\_\_\_\_  
(signature of person signing on behalf of patient)

\_\_\_\_\_  
(relationship patient name) (witness) (date)

I hereby certify that I have informed the patient of the nature of the procedure(s) to be performed and the inherent risks involved, including those outlined above.

\_\_\_\_\_  
(signature of physician) (date)



**PRENATAL COUNSELING CERTIFICATION**

I, \_\_\_\_\_ certify that:

1. I have been counseled by \_\_\_\_\_ on the date specified next to my signature below, regarding the dangers to my fetus from cigarette smoking, alcohol use, and the use of controlled substances during my pregnancy.
2. I understood the information he/she provided during this counseling.
3. I had an opportunity to ask questions and all of my questions (if any) have been answered to my satisfaction.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Date



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## **NEWBORN BABY INSURANCE FORM**

Please complete the following information so that we can better assist you with your insurance coverage.

Date \_\_\_\_\_  
Mother's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security \_\_\_\_\_

After delivery, will your child be added to the insurance information we currently have on file for your claims? Circle: YES or NO

**If NO, Please complete the information below.**

Name of Insurance Co. for Newborn \_\_\_\_\_  
Name of Insured on Policy \_\_\_\_\_  
Date of Birth of Insured \_\_\_\_\_  
Identification number of Insured \_\_\_\_\_  
Name of Employer for Insured \_\_\_\_\_

If this information changes, please notify the billing department immediately. It is patient responsibility to make sure all insurance information is current throughout the pregnancy, to ensure the insurance companies requirements are met in a reasonable length of time for certification on all medical care.

Please Note: Insurance does not guarantee payment and it is patient responsibility to know their benefit coverage.