Obstetrics and Gynecology Associates of Central Florida, LLC
Obstetrical History Form:

Date: _____

Who have you chosen as your Pediatrician? _____
What is your racial origin? ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian Other _____

How many pregnancies have you had? _____
How many babies did you carry full term? _____
How many premature deliveries have you had? _____
How many abortions have you had? _____
How many miscarriages have you had? _____ How many weeks at the time? _____
How many ectopic pregnancies have you had? _____
How many multiple births have you had? _____
How many living children do you have? _____
When was your last menstrual period? _____ (State Unsure if not known)
Were you on any type of birth control when you became pregnant? ☐ Yes ☐ No
At what age did you begin your menstrual cycle? _____
Are your periods regular (once a month)? ☐ Yes ☐ No
How long do your periods last? _____ When was your last pap/location? _____
Have you taken a pregnancy test? ☐ Yes ☐ No When was your first positive test? _____

List below information from your last pregnancies:

	1st	2nd	3rd	4th	5th	6th
Date month/year of Delivery?						
How many weeks at the time of delivery?						
How many hours were you in labor?						
Baby's birth weight?						
Male/Female?						
Type of Delivery? (Vaginal or Cesarean)						
What anesthesia (if any) was used?						
Name of Delivering hospital?						
Did you deliver premature? If yes, did you take progesterone injections?						

List any complication you may have had with any of the above pregnancies/deliveries:
☐ Gestational Diabetes
☐ Preeclampsia
☐ Other _____
☐ Post Partum Hypertension
☐ Take baby aspirin, Lovenox, Heparin during pregnancy.

Past/Current Medial History:

Do you have a history of any of the following? If yes, please give date you were first diagnosed and list any treatment or medication you may be taking:

	Yes:	No:	If Yes, Explain:
1. Diabetes	☐	☐	
2. Hypertension	☐	☐	
3. Heart disease:	☐	☐	
4. Autoimmune disorders:	☐	☐	
5. Kidney disease/Urinary tract infections:	☐	☐	
6. Neurologic/Epilepsy:	☐	☐	
7. Psychiatric/Depression:	☐	☐	
8. Hepatitis/Liver disease:	☐	☐	
9. Varicosities/Phlebitis:	☐	☐	
10. Thyroid dysfunction:	☐	☐	
11. Trauma /Domestic violence:	☐	☐	
12. History of blood transfusion:	☐	☐	
13. Tobacco usage:	☐	☐	
14. Alcohol:	☐	☐	
15. Street drugs:	☐	☐	
16. Pulmonary (asthma/tuberculosis):	☐	☐	
17. Allergies (Drugs/Latex):	☐	☐	
18. Breast disease/cancer:	☐	☐	
19. Gynecologic surgery:	☐	☐	
20. Operations/Hospitalizations:	☐	☐	
21. Anesthesia complications:	☐	☐	
22. History of abnormal pap:	☐	☐	
23. Uterine anomaly/D.E.S.:	☐	☐	
24. Infertility:	☐	☐	
25. Cancer of breast, ovary, or uterus.	☐	☐	
26. Stroke	☐	☐	
27. Twins	☐	☐	
28. GI disorders	☐	☐	
29. Other:			

List below any symptoms you may have experienced since your last menstrual period (Example: nausea, headache, fever):

Please indicate below if you or your family (Patient, baby's father, or anyone in either family) has a history of any of the following: If yes, describe in the comments area below:

Yes	No	
☐	☐	Your age will be over 35 years when you deliver this baby?
☐	☐	Thalassemia Trait (Italian, Greek, Mediterranean, or Asian background) MCV-DO
☐	☐	Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly)
☐	☐	Congenital Heart Disease
☐	☐	Down Syndrome
☐	☐	Tay-Sachs (ED, Jewish, Cajun, French Canadian)
☐	☐	Sickle Cell Disease (African)
☐	☐	Hemophilia
☐	☐	Muscular Dystrophy
☐	☐	Cystic Fibrosis
☐	☐	Huntington Chorea

☐ ☐ Mental Retardation
☐ ☐ Other inherited genetic or chromosomal disorder
☐ ☐ Maternal metabolic disorder (PKU, Insulin dependent diabetes)
☐ ☐ Patient or baby's father had a child with a birth defect.
☐ ☐ Recurrent pregnancy loss or stillborn.
☐ ☐ Medication/alcohol/street drugs since last menstrual period.
☐ ☐ Autism

Comments: _____

_____

Yes	No	
☐	☐	Do you have or have you been treated for Hepatitis A,B, or C?
☐	☐	Do you live with someone with TB (tuberculosis)?
☐	☐	Have you ever been exposed to TB?
☐	☐	Have you or your partner ever had Genital Herpes?
☐	☐	Have you had a rash or viral illness since your last menstrual period?
☐	☐	Have you ever had an STD (sexually transmitted disease)?
☐	☐	Have you ever had the Chicken Pox?
☐	☐	Do you have cats?

Comments: _____

_____

Pre-Pregnancy weight? _____ Height? _____

Current Medication _____

Circle one:

☐ Yes ☐ No Are you allergic to any medication?
☐ Yes ☐ No Are you against receiving blood transfusions?
☐ Yes ☐ No Have you felt the baby move? **If yes, When was the first time?** _____
☐ Yes ☐ No Have you had an ultrasound? **If yes, When:_____ Where:_____**
☐ Yes ☐ No Have you been treated by any other physician for this pregnancy or seen at the Emergency room? If yes, When and Where? _____

Patient Acknowledgement:

Obstetrics and Gynecology Associates of Central Florida, LLC are entering into a physician/patient relationship with you. We are reviewing your medical history and assessing our ability to care for you during your pregnancy. We are also agreeing to accept your insurance for the duration of this pregnancy. Therefore, if your situation should change, medically or financially, we may need to re-evaluate our relationship with you and it is possible that you may be discharged out of our care, if your new situation warrants a change.

Complications of pregnancy can require advanced treatment. There are physicians in our community, maternal fetal medicine specialists, who specialize in complicated, high risk pregnancy. If your pregnancy requires this type of treatment, we may refer/transfer you to a maternal fetal medicine specialist for consultation or, if necessary, for the duration of your pregnancy.

Our contractual relationship with many insurance companies limit the number of patients we may treat at any one time. For instance, we are limited in the number of patients we can care for with some insurance. If you change to one of these companies mid-pregnancy, we may need to discharge you from the practice.

Please sign below to indicate that you completed the above information to the best of your knowledge and have read and understand the patient acknowledgement.

Patient Signature _____ **Date** _____

Obstetrics and Gynecology Associates
Of Central Florida, LLC

Date: _____

This informed consent document discusses the risk and benefits of the different ways to deliver a baby, including vaginal delivery, vacuum delivery, forceps delivery and cesarean delivery. While most deliveries are joyous events, unfortunately certain high risk conditions, or just the process of having a baby, may lead to unforeseen complications. We believe that pregnant women and their families should be aware of the different routes of delivery, so that they may make an informed decision regarding their pregnancy. As always, please ask any questions you may have. Please do not sign this form until you have read it and understand its contents.

Vaginal Delivery

I understand that vaginal delivery may have unpredictable and unforeseen complications. Some of the possible complications of vaginal delivery include (not limited to):

Shoulder dystocia (after the delivery of the baby's head the shoulders of the baby are trapped in the vagina). This is an unforeseen and unpredictable event. It is an emergency that can lead to partial or total brain or physical damage to the baby. This includes but is not limited to damage to the nerves that control the arms and hands, the spinal cord, and the baby's neck, scalp, and collar bones.

Abruption placenta (separation of the placenta from the inside wall of the uterus), this can lead to severe blood loss, coagulation disorders, maternal death, and lack of oxygen to the baby which can lead to fetal death or permanent brain damage. Often this can lead to vaginal bleeding, but not always.

Uterine atony (the uterus will not contract properly after delivery or after cesarean section). This could lead to profuse bleeding with the need for a blood transfusion, emergency hysterectomy and prolonged recovery in the hospital or intensive care unit.

Postpartum bleeding due to retained placental tissue. Despite careful technique, a small piece of placenta may remain stuck to the inside wall of the uterus after delivery. This could lead to uterine bleeding requiring uterine curettage. This procedure may not stop the bleeding for a variety of reasons (placenta accreta, uterine atony, etc.) requiring hysterectomy (remove the uterus). One of the possible consequences of such a curettage is the development of intrauterine adhesions with the possibility of future infertility.

Nerve injuries due to position, compression or effort during the delivery process. These injuries may make it difficult to walk, and may require consultation with a neurologist (nerve specialist) and may lead to long term use of crutches, walkers, or other assisting devices.

Although controversial, there is some evidence that urinary incontinence and pelvic prolapse, where the muscles surrounding the vagina weaken, are more common after a vaginal delivery than cesarean delivery. However, just being pregnant regardless of the type, may lead to an increased risk of urinary incontinence. During vaginal delivery, the baby may create a tear between the vagina and anus, an area called the perineum. This tear may occur spontaneously, or via an episiotomy. Tears and episiotomies might have consequences including, but not limited to, scar tissue formation, painful sexual intercourse, infection, the perforation of a fistula (a hole between the vagina and rectum, where gas or feces escapes into the vagina uncontrollably, bleeding and even fecal incontinence).

Vacuum and Forceps Deliveries

A vacuum extractor is a plastic cup your doctor applies to the top of the baby's head to help deliver the baby vaginally. Forceps are metal instruments that your physician places a long side the baby's head to help guide the baby through the vagina. There are many reasons why a vacuum or forceps delivery may be warranted. Your physician will discuss these with you at the time of the delivery. However, on occasion the baby's heart rate will drop dangerously at the time of the delivery, or there will be profuse bleeding. Both of these are emergencies. Some patients wish for their doctors to deliver the baby vaginally if at all possible. Due to the need to deliver the baby as fast as possible, it may be necessary to use a vacuum extractor or forceps. Some patients prefer this over a cesarean delivery, whereas other patients do not want their physician to use vacuum or forceps, and prefer a cesarean delivery.

It is always preferable to discuss these issues with your doctor prior to the time of an emergency, because it can be hard to concentrate when you are bleeding or your baby's heart rate is abnormal. We encourage you to ask any questions you may have. Vacuum and forceps each have possible risks and benefits. Vacuum devices have a higher chance of bleeding of the baby's scalp or brain and the development of jaundice. Forceps have a higher chance of damage to the mother's vagina and anus with the potential for fecal incontinence or formation of a fistula. Both have a higher chance of shoulder dystocia than spontaneous vaginal delivery and cesarean.

The risk of bleeding into the baby's brain, although uncommon, is somewhat higher for vacuum deliveries than forceps deliveries. It is least common for planned cesarean deliveries, slightly more common for spontaneous vaginal deliveries, and most common for forceps and vacuum deliveries.

Cesarean Delivery

Cesarean deliveries, sometimes called "cesarean sections," involve making an incision into the lower abdomen and delivering the baby by abdominal surgery. As described above, there are several risks versus benefits one should consider when comparing cesarean delivery to vaginal delivery. Although controversial, cesarean delivery likely decreases the risk to the baby of shoulder dystocia and injury to the baby during delivery. Cesarean deliveries may also decrease the risk of developing urinary and rectal incontinence. However, cesarean deliveries may lead to more babies needing respiration care after delivery due to amniotic fluid within the lungs.

Cesarean delivery is a major surgical procedure, which, along with all surgical procedures, has certain risk and benefits. These include but are not limited to infection, profuse bleeding (which may require blood transfusion and removal of the uterus, called a hysterectomy), blood clots (in the legs, pelvis area, abdomen, and lungs), pneumonia, damage to internal organs, (like the bladder, intestines, female organs, or muscles and nerves), and the potential for the incision to open up after the procedure. All of these may require a longer time in the hospital or intensive care unit, or the need for the further surgery or procedures. Unfortunately, undergoing a cesarean delivery may lead to scar tissue within the abdomen or uterus, making it harder to get pregnant in the future. Also, such scar tissue may lead to abdominal pain and painful intercourse. The need for blood transfusion or blood product may increase the risk of acquiring AIDS, hepatitis and other transmissible diseases. In addition, having a first cesarean delivery increases the risk of later suffering a uterine rupture during vaginal delivery which may lead to future cesarean deliveries.

Patient Signature _____ Date _____

Obstetrical Information Consent:

Date:_____

1. I, the patient understand that Obstetrics and Gynecology Associates have many providers. Dr. Winger, Dr. Reinoso and Dr. Starr are the three providers who deliver babies in the practice. One of these providers will be on call on the day that I go into labor and any of them may deliver my baby. I agree to allow these providers to share in my care during my pregnancy.

   _____ Initial

2. There is a charge to complete all disability and FMLA forms. The charge is $15.00 per form. It will be necessary to pay the fee prior to forms being released to you. Please allow 5-7 business days for completion of forms.

   _____Initial

3. Obstetrics and Gynecology Associates provide obstetrical delivery services at Florida Hospital Celebration. We do not regularly staff any other Osceola/Orange County hospital for obstetrical care. A patient who requires emergency room care should proceed to Florida Hospital Celebration if she desires our physicians to care for her. Patients who visit any other hospital will be treated by staff physicians at the hospital and our physicians will NOT likely be notified that the patient is in the emergency room. Our physicians prefer to be involved in every part of your medical care. They encourage you to visit Florida Hospital Celebration for any medical need you may have during your pregnancy.

   _____Initial

4. Due to Hospital guidelines, all scheduled deliveries, whether by induction or by cesarean section, will be allowed only after the patient has reached a gestational age of 39 weeks or greater. We will not be allowed to schedule your delivery prior to 39 weeks unless medically necessary. But, if you go into labor on your own, this restriction does not apply.

   _____Initial

I have read the above information and understand the guidelines of the practice.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Consent for Testing

Cystic Fibrosis:

I, the patient, acknowledge that the Physicians at Obstetrics & Gynecology of Central Florida, have offered the carrier screening for CF. I understand that the purpose of this test is to determine if I am a carrier of Cystic Fibrosis.

_____ I *DO* wish to have the CF test performed.

_____ I *DO NOT* wish to have the CF test performed.

HIV:

I, the patient, have been counseled about the benefits of HIV testing & have been offered the test. I have been counseled about the treatment available to reduce the transmission of HIV from HIV infected women to their babies. With that knowledge, I hereby decline HIV testing.

_____ I *DECLINE* HIV testing.

NT Screening:

I, the patient, acknowledge that the Physicians at Obstetrics & Gynecology Associates of Central Florida, LLC have offered me the Nuchal Translucency Screening, also known as the NT. The purpose of this test is to screen for birth defects of my unborn child. These birth defects include Down Syndrome and Trisomy 18. I am aware that this screening is not 100% accurate & further testing might be offered if my test comes back with an" increased risk" result. The NT screening consists of blood work & an ultrasound. The 2nd part of this test known as Sequential Screening is drawn between 15 & 22 weeks gestation and tests for Open neural Tube Defects. This test may NOT be a covered benefit by my insurance. I, the patient take full responsibility of all fees pertaining to this screening if my insurance does not cover it.

_____ I DO wish to have the NT/Sequential Screening performed.

_____ I DO NOT wish to have the NT/Sequential Screening performed.

Quad Screen:

I, the patient, acknowledge that the Physicians at Obstetrics & Gynecology Associates of Central Florida have offered me the Quad Screen. I understand that the purpose of this test is to screen for birth defects of my unborn child. These birth defects include Down Syndrome, Trisomy 18 and Neural Tube defects.

_____ I *DO* wish to have the Quad Screening performed.

_____ I *DO NOT* wish to have the Quad Screening performed.

All of my questions about the above offered testing have been answered.

Patient Signature _____ **Date:**

Witness Signature _____ **Date:** _____

INHERIGEN AND INHERIGEN PLUS CONSENT

INHERIGEN AND INHERIGEN PLUS: This is a pan ethnic panel of tests that detects over 160 autosomal recessive diseases (Inherigen) and the Inherigen TX which covers 67 treatable diseases. These pan ethnic diseases are less common than those described above. It includes the tests that have typically been called a "Jewish Panel" to detect diseases that were previously thought to occur most common in the Jewish population, which we now know occurs in other ethnic groups as well. Because of the large number of diseases tested, this panel will detect an abnormality 25% of the time. When an abnormality is detected, the father of the baby needs to be tested because the disease can only affect the baby if both parents carry the same abnormal gene. Inherigen Plus includes Cystic Fibrosis, SMA and Fragile X. The self pay cost for Inherigen is $395 and for Inherigen Plus (which includes CF, SMA and Fragile X, is $495. If one partner is positive then the other partner needs to be tested for that specific gene that was reported to be abnormal at a self-pay cost of $150 each.

Please consider the following when you are making your decision about testing for autosomal recessive genes.

1. The purpose of the test is to determine if I or my partner are carriers for these diseases.
2. The tests do not detect all carriers of these diseases.
3. The laboratory will need details of family history in order to accurately interpret the test results.
4. The decision whether to have any of these tests is entirely mine to make
5. No other tests will be preformed and reported on my samples unless authorized by my Doctor, and any unused portion of my blood sample will be destroyed by the laboratory.
6. The laboratory will disclose the test results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or as required by law.

I/We have been offered genetic testing by Obstetric and Gynecology Associates of Central Florida, LLC and its benefits. By signing below, I:

_____ Request to have the Inherigen testing done

_____ DO NOT want the Inherigen testing done

_____ _____

Patient Signature Date