Women's Health Care Specialists

Obstetrical Questionnaire

Patient Name_____

		Circle Appropriate Answer	
1.	Will you be 35 or older when the baby is due?	Yes	No
2.	Have you ever had a blood transfusion?	Yes	No
	Have you or the baby's father or anyone in either of your families ever had:		
3.	Thalassemia or of Italian, Greek, Mediterranean, or Asian background	Yes	No
4.	Neural tube defect (meningomyelocele, spina bifida, anencephaly)	Yes	No
5.	Congenital heart defect	Yes	No
6.	Down syndrome	Yes	No
7.	Jewish, French Canadian	Yes	No
	(If # 6 yes) Tay-Sachs:	Yes	No
	(If # 6 yes) Canavan's Disease	Yes	No
8.	Sickle cell disease or trait (African)	Yes	No
9.	Hemophilia or other blood disorders	Yes	No
10.	Muscular dystrophy	Yes	No
11.	Cystic fibrosis	Yes	No
12.	Huntington's Chorea	Yes	No
13.	Mental retardation/autism	Yes	No
	(If yes) Was that person tested for Fragile X	Yes	No
14.	Other inherited genetic or chromosomal disorder	Yes	No
15.	Maternal metabolic disorder (DM, PKU, etc)	Yes	No
15a.	Patient or FOB with a child with a birth defect not listed above	Yes	No
16.	Patient or FOB with a birth defect themselves	Yes	No
17.	Recurrent pregnancy loss, or stillbirth	Yes	No
18.	Any medications since LMP other than prenatal vitamins (include vitamins, supplements, OTC meds, drugs, alcohol)	Yes	No
19.	Any other genetic/environmental exposure to discuss	Yes	No

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Phone: - 301-459-4317, Fax: 301-798-5009

6355 Walker Lane, Suite 303, Alexandria, VA 22310
Phone: - 571-316-2954, Fax: 571-316-2952

URL: https://www.whcsmd.com ***e-mail: service@whcsmd.com***

Infection History:

1.	Lives with someone with TB or TB exposed	Yes	No
2.	Patient or partner has history of genital herpes	Yes	No
3.	Rash or viral illness since LMP	Yes	No
4.	History of STD (GC, CT, HPV, syphilis, HIV)	Yes	No
5.	Other: _____		

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Informed Consent for Obstetrics

It is with a great deal of joy and excitement that we congratulate you on your pregnancy. There is not a better time in life to enjoy than the anticipation of having a child and the beginning of a new family member. It is indeed one of the most wonderful times of life and it is our intent for you to have the best experience humanly possible with this pregnancy.

It is, however, necessary that we inform you of certain risks that you need to be aware of with this pregnancy. Even though we have had great technological advancements in the delivery of health care, obstetrics, labor and delivery are not yet risk free situations. There are many unforeseen events that can occur during a pregnancy and you need to be aware that even though we take as many precautions as needed, there still may be a chance that something would go wrong such that you would not get a perfect baby.

Specifically, you need to understand the following risks: there is a 6-8% chance that any given pregnancy will be delivered premature. There is a 2-3% occurrence of major congenital malformations or birth defects in the general population, 2/3 of which are from an unknown cause. With any delivery, there is a 3% risk that the child will be born with mental retardation. Overall, in the U.S., the perinatal mortality rate is 14 per 1000 births. That figure becomes much higher when the mother is younger than 20 or older than 40. Poor nutrition, the development of diabetes, alcohol use, smoking, having herpes, etc., all increase these risks. The risk of Cystic Fibrosis in the Caucasian population is 1 in 2500 live births. Screening can detect approximately 85 % of potential carriers.

Of course, you can help reduce these risks with proper nutrition, stopping smoking, avoidance of alcohol and close prenatal follow-up and care with our office. You need to realize that even with optimal care anything can go wrong, such as a tight umbilical cord around the baby's neck, a trapped shoulder or premature separation of the placenta, not producing a perfect baby.

We trust that this information has been helpful to you and we regret the necessity of informing you of these risks, but it is necessary that you understand them. We, of course, will endeavor to provide the highest, quality, comprehensive care we can for you and your family.

Thankyou,
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Acknowledged this date: _____

_____
Patient Signature

OB Consent

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Consent for the Anti-HIV Blood Test

I have been informed that my blood will be tested in order to detect whether or not it contains antibodies to the human immunodeficiency virus (HN) which is the probable causation agent of acquired immune deficiency syndrome (AIDS). I understand the test is performed by drawing blood from my arm and processing the resulting specimen utilizing ELISA and Western Blot laboratory technology.

I have been informed that the ELISA test being utilized produces three (3) false positives (indicates presence of anti-HIV when it is not present) test results in every ten thousand (10,000) specimens processed, regardless of populations tested. I have also been informed that the test will be repeated, if positive, and a secondary level test (Western Blot) will be performed. The combination of these tests reduces the possibility of a false positive to a very small fraction per ten thousand (10,000) tests processed.

I have been informed the ELISA test also fails to detect anti-HIV in rare instances and for a period immediately after infection with the virus. I have been offered re-testing if it is suspected that this has occurred.

I have been informed that if I have questions regarding the nature of the blood test, the expected benefits, the risks and alternative tests, I may ask questions before I decide to consent to the blood tests.

I have been informed that all positive HIV test results will be reported to the Health Department for partner notification. I have been informed that this reporting process does not require my consent and is mandated by law.

By my signature below, I acknowledge that I have been given all the information I have requested concerning this blood test. Therefore, I acknowledge that I have given consent for the performance of a blood test to detect antibodies to HN.

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Patient Billing Consent: I further recognize that this testing will be filed for payment with my health insurance company.

Date: _____

Signature of Patient or Guardian: _____

Printed Name: _____

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