

NATIVITI WOMEN'S HEALTH & BIRTH CENTER

CONFIDENTIAL SELF-MEDICAL HISTORY

Please complete this form as accurately as you can. Please Print.

Name _____ **Date of Birth** _____ **Age** _____
Address _____ **Apt. #** _____ **City** _____ **State** _____ **Zip** _____
Home # _____ **Cell #** _____ **Race** _____ **Marital Status: M S D W**
SS# _____ **Employer** _____ **Phone** _____
Spouse _____ **Date of Birth** _____ **SS#** _____
Employer _____ **Phone** _____ **Type Work** _____

INSURANCE INFORMATION

Primary Insurance _____ **Insurance Phone** _____
Insured Name _____ **Policy #** _____ **Group #** _____
Insurance Phone _____ **Address** _____
Secondary Insurance _____ **Insurance Phone** _____
Insured Name _____ **Policy #** _____ **Group #** _____
Insurance Phone _____ **Address** _____
Special Contact Instructions: _____
Emergency Contact _____ **Relationship** _____
Address _____ **Phone** _____
Reason for visit? _____ **Referred by** _____

MEDICAL HISTORY

Have YOU Ever Had?	FAMILY History? Who?			Have YOU Ever Had?	FAMILY History? Who?		
Rheumatic Fever	Yes	No	_____	HIV/AIDS	Yes	No	_____
Lung Disease, Problems	Yes	No	_____	Thyroid Disorder	Yes	No	_____
Stomach Problems	Yes	No	_____	Abnormal Pap Smear	Yes	No	_____
Heart Problems	Yes	No	_____	Sexually Transmitted Disease -	Yes	No	_____
Kidney Disease	Yes	No	_____	HSV/ Chlamydia/Gonorrhea/Syphilis/HPV	Yes	No	_____
Cancer	Yes	No	_____	Anemia	Yes	No	_____
Liver Disease	Yes	No	_____	Blood Transfusion	Yes	No	_____
Chronic Urinary Tract Infection	Yes	No	_____	High Blood Pressure	Yes	No	_____
Mental Disorder	Yes	No	_____	Twins	Yes	No	_____
Post-Partum Depression	Yes	No	_____	Breast Disease	Yes	No	_____
Epilepsy	Yes	No	_____	Diabetes	Yes	No	_____
Hepatitis A B or C	Yes	No	_____	Fetal Anomalies	Yes	No	_____
Drug/Alcohol Abuse	Yes	No	_____	Other	Yes	No	_____

OTHER HEALTH CARE

- 1. Have you received medical care from a doctor, midwife or clinic in the past year? No Yes If yes, who and where?
- 2. Have you been in the hospital other than for childbirth?
No Yes If yes, list dates and reasons:
- 3. Have you had surgery? No Yes List with dates:
- 4. Do you regularly take any medications? No Yes If yes, list:
- 5. Do you take vitamins? No Yes Type:

ALLERGIES

- 6 Do you have allergies? No Yes If yes, to what?

SOCIAL

- 7. Weight -- would you like to lose, gain, neither?
- 8. How much would you like to gain or lose? _____ lbs.
- 9. How many cigarettes do you smoke a day? _____
- 10. Alcohol -- how many drinks? Weekday _____, Weekend _____
- 11. Have you used drugs like uppers, downers, grass, cocaine, crack/crank, LSD heroin, etc? No Yes
- 12. Do you feel safe in your current status? No Yes
- 13. How many years of education completed? You _____
Spouse _____

SEXUAL

- 14. Are you sexually active? No Yes
- 15. How old were you when you first had sex? _____
- 16. Are you in a stable relationship now? No Yes
- 17. If so, for how long? _____ Mo _____ Yr
- 18. Have you had more than one sexual partner in the last year? No Yes
- 19. Circle any problems you have during or after sex:
None Pain/Discomfort Bleeding
- 20. Do you have any sexual concerns? No Yes
- 21. Have you ever been forced to have sex? No Yes

To my knowledge, the information given on this form is accurate.

Signature _____

Date _____

MENSTRUAL

- 22. Age at first period. _____
- 23. How often do you get your period? Every _____ days.
- 24. How many days do you usually bleed? _____
- 25. How many pads or tampons do you use per day? _____
- 26. First day of last menstrual period (LMP)? _____
- 27. Was this period normal? No Yes
- 28. Could you be pregnant now? No Yes
- 29 Are your periods usually regular? No Yes
- 30. Do you spot/bleed between periods? No Yes
- 31. Do you take medications for cramps: ? No Yes
- 32. Do you douche? No Yes How often? _____
- 33. Have you had a hysterectomy? No Yes
- 34. Do you use hormone replacement therapy? No Yes
If yes, type and dose _____
- 35. Have you ever had an abnormal Pap? No Yes
Colposcopy? _____ Cryo? _____ Biopsy ? _____
- 36. Do you check your breasts regularly? No Yes
History of breast disease? No Yes

BIRTH CONTROL

- 37. Have you ever had a pelvic exam? No Yes
- 38. Circle all of the birth control methods used in the past:
a. None b. Pill c. IUD d. Diaphragm e. Condom
f. Cervical Cap g. Spermicidal h. Sponge i. Rhythm/Fam
j. Withdrawal k. Norplant l. Depo Provera
m. Sterilization (Self, Partner)
- 39. Describe any problems you have had with birth control: _____

- 40. What method are you using now? _____

- 41. What method do you want today? _____

PREGNANCY

- 42. Total number of times pregnant? _____

Number		Dates
a. _____	Vaginal Deliveries	_____
b. _____	Caesarean Sections	_____
c. _____	Abortions	_____
d. _____	Miscarriages	_____
e. _____	Stillbirths	_____
f. _____	Premature Deliveries	_____
g. _____	Ectopic Pregnancies	_____
h. _____	Twin Deliveries	_____
i. _____	Living Children	_____
j. _____	Genetic Problems	_____

- 43. Children(s) Names _____

- 44. Describe problems with pregnancy, delivery or abortion: _____

- 45. Do you want children in the future? No Yes

WELL WOMAN ANNUAL UPDATE

Name _____ Age _____ Today's Date _____
 Address _____ City _____ Zip _____
 Home Phone _____ Cell Phone _____
 Insurance _____ Phone _____
 ID# _____ Group# _____

First Day of Last Menstrual Period _____ Date of last PAP Smear _____
 Method of contraception (circle one): condom, tubal ligation, IUD, vasectomy, birth control pill (brand _____), other _____
 Total previous pregnancies _____ Vaginal Deliveries _____ C-Sections _____
 Miscarriages _____ Terminations _____ Ectopic Pregnancies _____

List previous surgeries and hospitalizations		List all medications you take regularly:	
Year	Type of Surgery or Illness	Name	Reason taken

List allergies to medications: _____
 Do you have any health problems or concerns? _____

For Office Use Only:

EXAMINATION RESULTS Ht: _____ B/P: _____ Wt: _____
 Breasts: NL _____ ABN _____ FC _____ Cervix: NL _____ ABN _____
 Abd: NL _____ ABN _____ Adnexae: NL _____ ABN _____
 Ext Gen: NL _____ ABN _____ Uterus: NL _____ ABN _____
 Vagina: NL _____ ABN _____
 Rectal: NL _____ ABN _____ GUIAC: NEG _____ POS _____
 IMP: NL WELL WOMAN EXAM _____

PLAN: PAP DONE _____ Mammogram _____ Cholesterol _____

 Provider Signature

NATIVITI WOMEN'S HEALTH AND BIRTH CENTER, INC**Consent for Examination, Treatment and Release of Records,
Prenatal, Birth, Newborn and Well Woman Care**

Name: _____ Phone: _____

DOB: _____ SS# _____

Address: _____

I authorize and direct the staff of Nativiti Women's Health & Birth Center to examine me and perform those procedures necessary for prenatal and/or family planning care and/or women's health care, and child health care. Procedures that may be performed include, but are not limited to:

Medical history and physical examination, including pelvic and breast examination
Spontaneous vaginal delivery of low risk women, including any necessary procedures
Blood work to screen for syphilis, anemia, rubella, diabetes, hepatitis, HIV
Urinalysis, urine culture and drug screen
Gonorrhea/Chlamydia culture and Pap smear
Neonatal screening/newborn exam, circumcision (if desired)
External fetal monitoring or limited ultrasound as needed
Other appropriate lab work

I understand that my care and examinations will be provided the Medical Team Staff, primarily comprised of Certified Nurse-Midwives, but also including consulting physician(s), independent non-associated physicians, or members of the Nativiti Women's Health & Birth Center staff including, but not limited to RN's, licensed midwives, midwife assistants, student nurse-midwives or nursing students.

I authorize release of any information required for payment of charges for services rendered by Nativiti Women's Health & Birth Center. I further authorize release of information to any hospital or medical facility I present myself to for medical care. I understand that I am responsible for all charges associated with services provided by the Center and its staff, including any balance not paid by third party payers. I understand that failure to make payment by the scheduled payments date may be ground for dismissal from care at the discretion of the director of the Center.

The nature of the procedures listed, as well as the likelihood of other, unforeseen complications and treatment, have been explained to me to my satisfaction and no warranty or guarantee has been made as to the result of treatment given me or my infant by the Medical Team Staff whether in the Center or in any other hospital or facility related to care during my pregnancy, delivery and postpartum period. This contract, along with the "Informed Consent Part I" and "Consent Form - Part II" form the entirety of the representations made to me and form the entire contract between Nativiti Women's Health & Birth Center and myself regarding my care.

Notice: "Nativiti", "Center" or "Nativiti Women's Health & Birth Center" are references to a legal corporate entity registered and doing business in the State of Texas -- Nativiti Women's Health and Birth Center, Inc., The Woodlands, Texas.

Patient's Signature: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

NATIVITI WOMEN'S HEALTH AND BIRTH CENTER

ACKNOWLEDGEMENT FORM:

I have received the Notice of Privacy Practices and/or I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____ Date _____

_____ (Initial) I hereby refuse to acknowledge receipt of the Notice of Privacy Practices and refuse to read or acknowledge any of the terms and conditions thereof. I understand that even though I may refuse to sign this acknowledgement, Nativiti Women's Health and Birth Center may still provide treatment.

Signature _____ Date _____

For Office Use Only

I, _____ acting as the staff representative for Nativiti Women's Health and Birth Center attempted to obtain the written acknowledgement of receipt of the Notice of Privacy Practices on _____ (date attempt was made), but acknowledgement could not be obtained because:

_____ (Initial) Patient or Patient's legal representative refused to sign.

_____ (Initial) Patient or Patient's legal representative could not be communicated with sufficiently to obtain acknowledgement.

_____ (Initial) Emergencies circumstances prevented securing acknowledgement.

_____ (Initial) Other _____

Signature of Representative _____ Date _____