

**We at CIRCLEHEALTH OB/GYN would like to congratulate you on your pregnancy and share with you your plan for obstetrical care. We invite you to access our website @www.womanhealth.net for more detailed information regarding your pregnancy care.**

**PREGNANCY EVALUATION**

Once your pregnancy has been confirmed, we will schedule your first set of appointments. Our practice offers an informational class for patients and partners about your pregnancy experience. This will be your first appointment. The class is one hour in length. It includes an overview of your visits, explanation of testing and expectations for each trimester. We strongly encourage all our patients to experience the class as there is new technology and testing we want you to be aware of even if you have had other pregnancies.

The second visit will be with a Nurse Practitioner. We will review your medical history, pregnancy history, and do a complete physical exam including your blood tests.

Your first ultrasound will be scheduled after your first exam when your schedule of appointments are made. **Please be advised you may not have an ultrasound at your first visit.**

Your third appointment will be a prenatal visit with a physician in the first trimester.

If any complications arise before your first visit, please call the office and we will have you see one of the providers as soon as possible for the particular problem.

**PRENATAL CARE**

Our staff consists of Obstetricians, Nurse Practitioners, and Nurse Midwives. We do have male providers who may delivery your baby.

There is a Doctor from this practice on-call every day at the hospital. For your office visits you may choose to receive your prenatal care with one physician or meet all the providers throughout your pregnancy. The choice is yours. The Doctor on-call the day you come into the hospital in labor is the Doctor who will deliver your baby.

These visits are scheduled by appointment according to where you are in your pregnancy. If you need to be seen for a problem, an additional appointment will be made for you. We have 3 offices located in North Chelmsford, Westford, and Dracut. You may schedule appointments at any site.

Our deliveries are done only at LOWELL GENERAL HOSPITAL Main Campus.

***Test results are available to you on the Cerner Patient Portal for Lowell General Hospital. We encourage you to sign up for this service so you may access your results.***

**CONTACTING THE OFFICE**

When calling the office with a problem or concern, **please identify yourself as a pregnant patient. We do not accept blocked phone numbers.** Due to our large volume of calls we do use a voicemail system. If your matter is an emergency press 1 on the prompt. Otherwise leave a message for the triage nurse on line 3. She will return your call as soon as possible.

If the office is closed, our answering service will refer your call to the doctor on call. **Please identify yourself to the answering service as a pregnant patient. If expecting a call from the doctor, you must remove any blocks on your phone.**

**EDUCATION AND NUTRITION**

We provide a packet of information at the beginning of the first and third trimester which we believe addresses most issues concerning good prenatal care.

If you have any questions or concerns that are not answered in this packet, please let us know.

Lowell General Hospital offers many classes for our patients in childbirth education, hypnobirthing, exercise programs, sibling classes and support groups. If you are interested just give them a call at

1-877-544-9355 or go on-line at [www.lowellgeneral.org](http://www.lowellgeneral.org).

Proper nutrition is an important part of good prenatal care. We work with the nutritionists from Lowell General Hospital and refer to them for any special dietary needs.

**BIRTH EXPERIENCE**

The labor and delivery experience will be discussed in more detail the last months of pregnancy. Please let us know what your needs and concerns are so that we can help to make your birth experience a memorable one.

**WE LOOK FORWARD TO WORKING WITH YOU AND YOUR FAMILY TO ACHIEVE OUR GOAL: A HEALTHY MOTHER AND BABY!**

Michelle Cochran, M.D. Minerva Domingo, M.D.

Kristin D’Orsi, M.D. Karen Fortune, M.D

William J Galvin, M.D. Katherine Van Savage, M.D

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Neil O’Regan, M.D Irene Lewnard, M.D.

Marybeth Marcotte, NP Judy Bain, NP Kyla Malone, NP Raquel Sully, NP

Kathleen Cullen – Lutter, CNM Maureen McSwiggin, CNM

Shelagh Galvin, CNM

 Form: E-3

 1/28/2020



*Patient Label*

**PATIENT INFORMATION:**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

SS #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_ First Name Used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Former Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language Spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you require an interpreter? Yes or No

**PHARMACY:**

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Insurance Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male – Female

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check here if address is the same as the patient.

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN INFORMATION: (*Fill this section ONLY if this registration is for a child under 18*)**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Preference: Home or Cell

 Check here if address is the same as the patient. Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I give permission for my provider to contact me by home, work, or cell phone and or CircleHealth patient portal.**

**My preference is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**Is it permissible for provider to leave a message regarding test results? YES or NO**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Patient Signature and/or Parent/Legal Guardian Date**

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Label*

**PATIENT MEDICAL HISTORY**

**Please complete the following questionnaire to the best of your ability. If there are any questions you prefer not answering leave them blank.**

**FAMILY HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
|  **Age ↓** | **Living** | **Deceased** | **Cause of Death** |
| Mother - |  |  |  |
| Father - |  |  |  |
| Sister - |  |  |  |
| Brother -  |  |  |  |
|  |  |  |  |

Have any members of your **immediate family** had the following:

 **Circle Answer**  **Relation**

Cancer:

* Breast Yes / No Mother – Father – Sister – Brother
* Colon Yes / No Mother – Father – Sister – Brother
* Ovarian Yes / No Mother – Father – Sister – Brother
* Uterine Yes / No Mother – Father – Sister – Brother

Diabetes Yes / No Mother – Father – Sister – Brother

Endometriosis Yes / No Mother – Father – Sister – Brother

Fibroids Yes / No Mother – Father – Sister – Brother

Heart Disease Yes / No Mother – Father – Sister – Brother

High Blood Pressure Yes / No Mother – Father – Sister – Brother

Kidney Disease Yes / No Mother – Father – Sister – Brother

Stroke Yes / No Mother – Father – Sister – Brother

DVT (Blood Clot) Yes / No Mother – Father – Sister – Brother

**MEDICATIONS:** Please list all prescription and non-prescription medicine

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dose** | **Frequency** |
|   |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES:** Please list all known allergies

|  |  |
| --- | --- |
| **Allergy** | **Reaction or Side Affect** |
|  |  |
|  |  |
|  |  |
|  |  |

**SURGICAL HISTORY AND HOSPITALIZATIONS:** Does not refer to pregnancies

|  |  |
| --- | --- |
| **Surgery / Hospitalizations / Name of Hospital** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |

**PERSONAL MEDICAL HISTORY**

**Immunizations:**  **Circle Answer Year**

Chicken Pox Yes / No \_\_\_\_\_\_\_\_\_\_

 Measles – Mumps – Rubella (MMR) Yes / No \_\_\_\_\_\_\_\_\_\_

 Hepatitis B Yes / No \_\_\_\_\_\_\_\_\_\_

 Tetanus Yes / No \_\_\_\_\_\_\_\_\_\_

 Gardasil Yes / No \_\_\_\_\_\_\_\_\_\_

 Influenza (Flu) Yes / No \_\_\_\_\_\_\_\_\_\_

 Have you ever had the following problems? **Circle Answer Year**

Anemia Yes / No \_\_\_\_\_\_\_\_\_\_

Bone Disease Yes / No \_\_\_\_\_\_\_\_\_\_

Cancer Yes / No \_\_\_\_\_\_\_\_\_\_

Depression/Anxiety Yes / No \_\_\_\_\_\_\_\_\_\_

Diabetes Yes / No \_\_\_\_\_\_\_\_\_\_

Heart Problems Yes / No \_\_\_\_\_\_\_\_\_\_

Hepatitis Yes / No \_\_\_\_\_\_\_\_\_\_

Hypertension Yes / No \_\_\_\_\_\_\_\_\_\_

Immune Disorder Yes / No \_\_\_\_\_\_\_\_\_\_

Kidney Problems Yes / No \_\_\_\_\_\_\_\_\_\_

Migraine Headaches Yes / No \_\_\_\_\_\_\_\_\_\_

Muscle Disease Yes / No \_\_\_\_\_\_\_\_\_\_

Thrombophlebitis Yes / No \_\_\_\_\_\_\_\_\_\_

 Any Reactions to Anesthesia Yes / No \_\_\_\_\_\_\_\_\_\_

MRSA / VRE Yes / No \_\_\_\_\_\_\_\_\_\_

Blood Transfusions Yes / No \_\_\_\_\_\_\_\_\_\_

Are Blood Transfusions acceptable to you? Yes / No

**PREGNANCY HISTORY:** **Please list ALL pregnancies OR new pregnancies since last visit.**

**How many times have been pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many children have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Month/Year** | **Place of Delivery** | **Length of Pregnancy** | **Type of Delivery** | **Complications** | **Gender** | **Birth Weight** | **Present Health** |
|  |  |  |  |  |  |  |  |
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**MENTRUAL HISTORY PAPSMEAR / MAMMOGRAM HISTORY**

Do you still have a period? Y / N Date of last pap? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, age at which you stopped? \_\_\_\_\_\_ Have you ever had an abnormal pap: Y / N Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Age of first menses? \_\_\_\_\_\_ Date of last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems with your periods? Y / N Have you ever had an abnormal mammogram? Y / N Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SOCIAL HISTORY**

**CONTRACEPTION**

 Smoker? Y / N Never Former

Are you currently sexually active? Y / N Alcohol? Y / N Never Frequency? \_\_\_\_\_\_\_\_\_\_\_\_

Current sexual partner? Male or Female Recreational drugs? Y / N Frequency? \_\_\_\_\_\_\_\_\_\_

Method of birth control currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seat belt use? Y / N Exercise? Y / N Frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you safe at home? Y / N

 Any history of abuse or violence in your relationships? Y / N

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**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRENATAL QUESTIONNAIRE**

1. Have you lived or traveled outside of the US in the past year? Yes No
2. Will you be thirty-five years of age or older when the baby is born? Yes No
3. Have you, the baby’s father, or anyone in either of your families ever had anyone of the following disorders?

 Downs Syndrome Yes No

 Any chromosome abnormality including Fragile X Yes No

 Neural tube defects (spina bifida, meningocele, anencephaly) Yes No

 Hemophilia Yes No

 Muscular Dystrophy/Huntington’s Chorea Yes No

 Connective tissue disease Yes No

 Neurological disorders Yes No

 Birth defects Yes No

 Mental retardation Yes No

 Tay Sachs disease (Jewish, French Canadian ancestry) Yes No

 Thalassemia/Anemias (Southeast Asian, Chinese, Pakistani ancestry) Yes No

 Sickle Cell disease (African American ancestry) Yes No

 Cystic Fibrosis Yes No

 PKU Yes No

 Congenital heart defects Yes No

 Any birth defects or conditions not listed here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you or the baby’s father had a stillborn child or three or more pregnancy loses? Yes No

 If yes, has either or you had any chromosome studies? Yes No

1. Are you or the baby’s father of Jewish, French-Canadian, African-American, or

 Mediterranean background? Yes No

1. Since your last period have you had any:

 Medications Yes No

 X-rays Yes No

 Recreational drugs Yes No

 Alcohol Yes No

1. Have you ever had a blood transfusion? Yes No
2. Would you accept a blood transfusion if needed? Yes No
3. Have you ever been diagnosed with:

Pre-eclampsia? Yes No

Chronic hypertension (high blood pressure)? Yes No

Type 1 or 2 diabetes? Yes No

Renal (kidney) disease? Yes No

Auto-immune disease (example: lupus, rheumatoid arthritis, Crohn’s disease)? Yes No

1. Have you been diagnosed with MRSA or VRE? Yes No



**5 P’S SCREEN FOR ALCOHOL/SUBSTANCE USE**

Did any of your **parents** have a problem with alcohol or drug use? ⃝ Yes ⃝ No

Do any of your **friends/peers** have a problem with alcohol or drug use? ⃝ Yes ⃝ No

Does your **partner** have a problem with alcohol or drug use? ⃝ Yes ⃝ No

In the past, have you had difficulties in your life due to alcohol or other drugs,

including prescription medications? ⃝ Yes ⃝ No

**PRESENT**

During this pregnancy did you drink alcohol? ⃝ Yes ⃝ No

1. What kind of alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many days per months did you drink? \_\_\_\_\_\_
3. How many drinks on any given day? \_\_\_\_\_\_\_\_

During this pregnancy did you use drugs? ⃝ Yes ⃝ No

1. What kind? (marijuana, cocaine, heroin, methamphetamines, prescription drugs) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many days per month did you use? \_\_\_\_\_\_\_\_\_\_\_\_\_
3. How much did you use on any given day? \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken prescription medications for non-medical use? ⃝ Yes ⃝ No

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