COLORADO NURSE-MIDWIVES

OBSTETRICAL HISTORY FORM

NAME:_____ Date of Birth:_____ Age:_____

How did you hear about Aurora Nurse Midwives?_____

Pharmacy Preference: (Cross Streets are helpful)_____

PREGNANCY HISTORY – (include miscarriages and abortions)								
Date (month/year)	Weeks Gestation	Length of Labor (hours)	Birth Weight	Sex (M/F)	Type of Delivery (vaginal/cesarean /vacuum/forceps)	Anesthesia (epidural/IV /spinal/general)	Place of Delivery	Comments / complications
/								
/								
/								
/								
/								
/								
/								
/								
/								
/								
***Current Pregnancy Father of Baby Name:_____ Involved? Yes / No								

MENSTRUAL / GYN ECOLOGY HISTORY	
Date of last menstrual period (day it began):	Was the amount and duration normal? Yes / No
Are you sure about the date? Yes / No	Are your periods monthly? Yes / No
Age at onset of periods:	Age at 1st intercourse:
Where you on birth control at time of conception? Yes / No	What form of birth control?
Date of your positive pregnancy test:	Was it a home pregnancy test? Yes / No
Date of your last Pap Smear:	What was the result of your last Pap Smear?
Have you ever been treated for an abnormal Pap Smear? Yes / No	If yes, what type of treatment?
Do you use condoms to prevent sexually transmitted infections (STI)? Yes / No	

SURGICAL HISTORY			
Date (month/year)	Surgery / Complications	Date (month/year)	Surgery / Complications
/		/	
/		/	
Have you ever had any problems with anesthesia? Yes / No, if yes what?			

HOSPITAL HISTORY (other than birth of your children)			
Date (month/year)	Reason / Complications	Date (month/year)	Reason / Complications
/		/	
/		/	

FAMILY HISTORY (diabetes, high blood pressure, heart disease, kidney disease, asthma, TB, Psychiatric, cancers, thyroid disease, epilepsy, hepatitis, other)					
Relationship	Alive	Comments	Relationship	Alive	Comments
Mother	Yes / No		Sisters, #_____	Yes / No	
Father	Yes / No		Significant Other/Spouse	Yes / No	
Maternal Grandmother	Yes / No		Children, #_____	Yes / No	
Paternal Grandmother	Yes / No		1st Cousins	Yes / No	

PATIENT LABEL

COLORADO NURSE-MIDWIVES

OBSTETRICAL HISTORY FORM

Maternal Grandfather	Yes / No		Aunts	Yes / No	
Paternal Grandfather	Yes / No		Uncles	Yes / No	
Brothers, #_____	Yes / No				

SOCIAL HISTORY			
Tobacco Use? Yes / No	If yes, years of use:	Packs/cigarettes per day prior to pregnancy:	Packs/cigarettes per day since pregnancy:
Alcohol Use? Yes / No	If yes, years of use:	Drinks per day prior to pregnancy:	Drinks per day since pregnancy:
Illicit / Recreational Drug Use? Yes / No	If yes, years of use:	What do you use? How often do you use?	
Caffeine Use: Coffee / Tea / Soda / Other:		How many per day?	
Do you Exercise? Yes / No ,What do you do?			How often?
Marital Status: Single / Married / Widowed / Divorced / Separated			
Who do you live with?			
Do you live with Cats? Yes / No			
Living environment: House / Condo / Apartment / Other			
Environmental Exposure: chemicals / second hand smoke / Other, Please explain			
Diet: (circle) Regular / Vegetarian / Vegan / Other			
Do you have any non-food cravings? Yes / No	If yes, what?		
Occupation / Work:			
Education / School: Highest Education level completed:		Are you currently in school? Yes / No	
Religious Preference:			
Personal Information: Race / Ethnicity:		Place of Birth?	Years in USA:
Other: Do you wear a seat belt? Yes / No			
Personal Safety			
Has anyone close to you ever threatened to hurt you? Yes / No		Are you afraid of your partner? Yes / No	
Has anyone ever hit, kicked, choked, or hurt you physically? Yes / No		Do you have guns in the home? Yes / No	
Has anyone ever forced you to have sex? Yes / No			

MEDICAL HISTORY			
Disease / Condition		Disease / Condition	
Diabetes	Yes / No	Trauma / Violence	Yes / No
Hypertension	Yes / No	History of Blood Transfusion	Yes / No
Heart Disease	Yes / No	D (Rh) Sensitized	Yes / No
Autoimmune Disorders	Yes / No	Pulmonary (TB, Asthma)	Yes / No
Kidney Disease / Urinary Tract Infections	Yes / No	Seasonal Allergies	Yes / No
Neurologic / Epilepsy	Yes / No	Breast Problems	Yes / No
Psychiatric / Anorexia / Bulimia	Yes / No	History of Abnormal Pap	Yes / No
Depression / Postpartum Depression	Yes / No	Uterine Anomalies / DES exposure	Yes / No
Hepatitis / Liver Disease	Yes / No	Infertility	Yes / No
Varicosities / Phlebitis	Yes / No	ART Treatment	Yes / No
Thyroid Dysfunction	Yes / No	Other	Yes / No
Vaccines	Date	Vaccines	Date
Chicken Pox: Disease / Vaccination		Flu	
Tdap (Tetanus, Diphtheria, Pertussis)		Gardasil (HPV)	

PATIENT LABEL

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OBSTETRICAL HISTORY FORM

GENETIC HISTORY		
Disease / Condition		Self / Family Member / Comments
Your age 35 years or older at time of delivery	Yes / No	
Thalassemia	Yes / No	
Neural Tube (Spinal cord) Defect (meningomyelocele, spina bifida, anencephaly)	Yes / No	
Congenital Heart Defect	Yes / No	
Down Syndrome	Yes / No	
Tay-Sachs	Yes / No	
Canavan Disease	Yes / No	
Sickle Cell Disease or Trait	Yes / No	
Hemophilia or Other Blood Disorders	Yes / No	
Muscular Dystrophy	Yes / No	
Cystic Fibrosis	Yes / No	
Huntington's Chorea	Yes / No	
Mental Retardation / Autism	Yes / No	If yes, was Fragile X tested? Yes / No
Other Inherited Genetic or Chromosome Disorders	Yes / No	
Maternal Metabolic Disorder (EG, PKU, Type 1 Diabetes)	Yes / No	
Baby's Father had child with birth defects not listed	Yes / No	
Recurrent Pregnancy Loss or Stillborn	Yes / No	
Other	Yes / No	

INFECTION HISTORY			
Do you live with someone with TB?	Yes / No	Gonorrhea	Yes / No
Have you been exposed to someone with TB?	Yes / No	Chlamydia	Yes / No
Have you ever had a positive PPD test?	Yes / No	HPV / Genital Warts	Yes / No
Do you or your Partner have a history of genital Herpes?	Yes / No	HIV / AIDS	Yes / No
Have you had a rash or viral illness since your last menstrual period?	Yes / No	Syphilis	Yes / No
Hepatitis B	Yes / No	Other	Yes / No
Hepatitis C	Yes / No	Other	Yes / No

MEDICATIONS / VITAMINS / SUPPLEMENTS			
Name	Dose & How Often	Name	Dose & How Often

ALLERGIES (food, medication, latex, seasonal, others)			
Name	Reaction	Name	Reaction

History assisted by _____ Date_____

PATIENT LABEL

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Health ONE Colorado Nurse Midwives
Physician Care℠

Routine OB Visit or Well- Woman Visit Financial Consent

If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive medicine evaluation and management service (OB revisit, well woman visit, post-partum visit) and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, Colorado Nurse Midwives will bill for both a well woman visit and a problem visit.

When billing Medicare/Medicaid (which specifies its own codes for many preventive services), any additional E/M service must be "carved out" from the preventive service. This portion of the service may be submitted to Medicare/Medicaid for coverage. The Medicare/Medicaid beneficiary may be billed for the difference between the standard fee for the preventive service and the amount that Medicare/Medicaid will cover.

Commercial payers' policies vary. Some will not pay for two evaluation and management services on one date of service, or may reduce payment for one of the services. It is the patient's responsibility to check with your insurance's coding policy, and the patient's benefits.

I understand that if treated for other concerns outside my scheduled visit, I may be charged additional fees.

_____ _____

Name Date

_____ _____

Signature Date of Birth