CARING CENTER FOR WOMEN PA

Please help us know more about you and your pregnancy. All information will be kept confidential.

Name: _____ Date: _____

Your Race: _____ Marital Status: _____ Occupation: _____

Your age at delivery: _____ Highest grade completed/degree: _____

Spouse/Partner's/Father of Baby's Name: _____ Age: ____ Race: _____

Occupation: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Total Number of Pregnancies (including this one): _____ Full term: _____ Preterm: _____

Elective Abortions: ____ Miscarriages: _____ Ectopic: _____ Number of living children: _____

First day of last menstrual period: _____

Is this date definite?	Yes	No
Was it normal in amount of flow and number of days?	Yes	No
Do your periods come every 28 days?	Yes	No
Were you using any birth control method when you conceived?	Yes	No

When did you last use birth control (pills, ring, shot): _____

When did you have a positive pregnancy test? _____

How old were you when you had your first period? _____

Height: _____ Pre-pregnancy weight: _____

Medical History Do you or YOUR family members (immediate, parents/siblings only) have any of the following? If yes, give details.

	Self	Immediate family
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Seizures		
Autoimmune Disease		
Psychiatric Disease (depression/postpartum depression		
Liver Disease		
Varicose Veins		

	Self	Immediate family
Blood Clotting problems		
Cancer		
Thyroid Disease		
Lung Problems (including asthma)		
Breast Disease		
Abnormalities of uterus or cervix		
Other		

Have **YOU** ever had any of the following? (Give details)

Trauma: _____ Blood Transfusion: _____

Gynecologic surgery: _____

Other surgeries or hospitalizations: _____

Problems with anesthesia: _____ Infertility treatment: _____

When was your last pap smear? _____ Have you ever had an abnormal pap smear? _____

(Give details of when and how it was treated) _____

When was your last tetanus shot? _____

	No	Yes (please give details)
Are you allergic to medications? If Yes, please list medication and reaction		
Are you allergic to latex?		
Do **YOU** smoke? If yes, please list how much and how long Are you willing to quit?		
Do **OTHERS** in your household smoke?		
Do YOU drink alcohol? If yes, please list how much you drink at one time How often do you drink? Have you quit?		
Do YOU use recreational/illicit drugs? If yes, how often? IV Drug use? Have you quit?		
Do you have any inside pets?		

Does the Father of the baby have any medical problems? (Give details)

_____

_____

_____

_____

List all pregnancies (including miscarriages and abortions)

Date M/D/YY	Birth Weight	Name	Length of labor	Vaginal or C -Section	Anesthesia	City, State	Complications with Pregnancy, Delivery, or Infant

Genetic Screening: Please include self, Father of baby, or any family members (yours or Father of baby's). If yes, please give details.

	NO	Yes (please give details)
Will you be age 35 or older as of delivery date?		
Are you or baby's father's family from an Italian, Greek, Mediterranean, or Asian Background?		
Any infants with an open spine (spina bifida), brain defect, or anencephaly?		
Any infants with heart defects?		
Any infants with Down syndrome?		
Are you or baby's father's family Jewish, Cajun, French – Canadian?		
Are you or baby's father African/Black? Any history of sickle cell disease/trait?		
Do you, baby's father, or family members have hemophilia or other blood disorders?		
Have you, baby's father, or family members had a child with muscular dystrophy or other muscular, neurological disorders?		
Do you, baby's father, or family members have cystic fibrosis?		
Have you, baby's father, or family members had a child with mental retardation or Autism (if yes, was person tested for Fragile X)		
Have you, baby's father, or family members had a child with other inherited genetic or chromosomal disorders?		
Have you, baby's father, or family members had a child with a birth defect not listed above?		
Do you have diabetes?		
Do you have PKU?		

	NO	Yes (please give details)
Have you or the baby's father had 2 or more pregnancies that ended in miscarriage?		
Have you taken any of the following drugs during your pregnancy or around the time the pregnancy began? • Seizure medications (epilepsy) • Anti-cancer drugs • Heart or blood pressure drugs • Anti-coagulants (blood thinners) • Lithium • Accutane • Medications for depression		
Since your last period, have you had drinks containing alcohol (beer, wine, liquor) <u>almost each day or frequently</u>?		
Since your last period have you used cocaine, marijuana, methamphetamines or any street drugs?		
Is there anything that you think could be a birth defect, genetic problem (inherited or one that runs in your of the father's family) that is not listed here:		

Medications: Please list any medications (prescriptions, over the counter, vitamins, herbs, supplements) you are currently taking, or have taken since you have been pregnant

Name of Medication	Dose (amount) and How Often Do You Take the Medication	Date Started	Why Do You Take The Medication	If Prescription, Doctor's Name, City, and State

Infection History: Have you or the baby's father had any of the following? (If yes, give details)

	NO	Yes (please give details)
Lived with Someone with TB or exposed to TB		
Genital herpes		
Experienced a rash or viral illness since your last menstrual period		
Hepatitis B or C		

History of Gonorrhea		
History of Chlamydia		
	NO	**Yes** (please give details)
History of HPV		
History of HIV		
History of Syphilis		
Other infection		

Please list any current or recent problems

	NO	**Yes** (please give details)
High fever (greater than 100.4 degrees) since your pregnancy began		
Eye pain or trouble with your vision		
Ear pain/ringing in your ears or trouble hearing		
Fainting or "passing out" since your pregnancy began		
Easy bleeding or bruising		
Significant or consistent pain in your back or extremities		
A cough that won't go away		
Seasonal allergies		
Chest pain		
Shortness of breath at rest or minimal exertion		
Swelling of hands or feet		
Consistent vomiting		
Consistent diarrhea or constipation		
Pain with urination		
Depression or anxiety		

Please list any questions or concerns that you may have or problems not listed elsewhere on this form.

_____

_____

_____

_____

_____

_____

If you have already had genetic testing for a hereditary cancer syndrome (BRCA) and your family history has not changed, you do not need to complete this form

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Has anyone in your family had genetic testing for a hereditary cancer syndrome? (Ex: BRCA or Lynch)? Yes or No

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis)
Y	N	Breast cancer (please note if it was triple neg)				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian/fallopian tube cancer				
Y	N	Male breast cancer				
Y	N	Are you of Jewish decent?				

COLON AND UTERINE CANCER (Colaris)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, biliary tract, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	N	Prostate Cancer (BRCA)				
Y	N	Pancreatic Cancer (Col/BRCA)				
Y	N	Melanoma				

Patient's Signature:_____ Date: _____

For Office Use Only:

BRCA/Lynch Testing Indicated?: YES NO

Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED

Follow-up appointment scheduled: YES NO Date of Appointment:_____

One person with (out to 2nd degree):	**BRCA – Personal or Fam. History**	**Lynch Syndrome (Colon/Endo)**
• Breast Cancer at 49 or younger • Ovarian Cancer at any age • Male breast cancer any age • Pancreatic cancer any age • Bilateral Breast at any age • Metastatic prostate cancer at any age • Triple Neg Br.Ca. at 60 or younger • Jewish ancestry w/ovarian, pancreatic or breast cancer any age • Personally affected w/breast cancer at any age	Two persons with (out to 3rd Degree) • 2 Breast Cancers, w 1 ≤ 50 or younger Three Persons with (out to 3rd degree) • Breast and/or Ovarian and/or Pancreatic (any age)/aggressive Prostate	Personally affected with: • Colon or Endometrial at ≤ 64 Family History out to 2nd Degree: • 1 Colon or Endometrial Cancer ≤ 49 • 10+ Colon polyps found in a lifetime • 2 or more Lynch* cancers in the same person • 2 or more Lynch* cancers w/1 dx ≤ 50 *(gastric, ovarian, brain, kidney, small bowel, pancreas, ureter, biliary tract)

MD Signature: _____ Date: _____

CARING CENTER FOR WOMEN PA

705 Generations Drive, Ste #101
New Braunfels, TX 78130
office: 830.387.4790
fax: 512.396.7555

1305 Wonder World Drive, Ste #203
San Marcos, TX 78666

CONSENT TO PERFORM HIV TESTING

Given the enormous advances in the prevention of perinatal transmission of human immunodeficiency virus (HIV), early identification and treatment of all pregnant women with HIV is the best way to prevent neonatal infection and improve women's health. This office follows ACOG and Texas state guidelines for HIV testing at the initial OB visit. Insurance companies are aware of ACOG and state guidelines for HIV testing and routinely cover this testing as part of your initial OB care with each pregnancy.

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:

- HIV is the virus that causes AIDS.
- The only way to know whether you have HIV is to be tested for it.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. You can withdraw consent at any time.
- Several testing options are available, including anonymous and confidential testing.
- State law may protect the confidentiality of test results and protects test subjects from discrimination based on their HIV status.
- If you test positive, your health care provider will talk with you about notifying your sex or needle-sharing partners of possible exposure.

I agree to a test for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing, which may occur on the sample I provide today, to determine the best treatment for me. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____
(Or signature of legally authorized representative)

If legal representative, indicate relationship to patient _____

Printed Name of representative _____

Certification

I certify that the named person above has been given an opportunity to read written information about HIV and to ask questions, that he or she understands the issues presented, that his or her decision to undergo HIV testing is an informed and voluntary one, and that I have witnessed his or her signature.

Witness Name _____

Witness Signature _____ Date _____

CARING CENTER FOR WOMEN PA

705 Generations Drive, Ste #101
New Braunfels, TX 78130
office: 830.387.4790
fax: 512.396.7555

1305 Wonder World Drive, Ste #203
San Marcos, TX 78666

Urine Drug Screen in Pregnancy Acknowledgement

Patient Name: _____ Date of Birth: _____

It is the policy of Caring Center For Women to perform a urine drug screen on all pregnant patients at the initial prenatal visit. The urine drug screen is a tool to help your physician provide the best prenatal care to you and your baby, both during and after pregnancy.

I understand that if my initial screen is positive, I may be asked to seek counseling for drug use, treatment for dependency, or be asked to undergo further testing as my pregnancy continues depending on my results and situation.

The purpose of the urine drug screen is not meant to be punitive or for criminal charges. It is to identify those at risk.

Positive test results will only be shared with essential medical professionals who are caring for you and your baby unless you give written consent or by court order.

The testing done by this office is a basic urine drug screen and is not one done for criminal or custody cases as there is no chain of custody involved.

I have been informed of Caring Center For Women's Urine Drug Screen Policy and understand the benefits and potential adverse consequences related to urine toxicology screening.

_____ _____

Patient Signature Date

CARING CENTER FOR WOMEN PA

705 Generations Drive, Ste #101
New Braunfels, TX 78130
office: 830.387.4790
fax: 512.396.7555

1305 Wonder World Drive, Ste #203
San Marcos, TX 78666

Transfusion Consent

I _____ do or _____ do not consent to the use of blood or blood products as deemed necessary if the event of an emergency or significant need.

Possible complications of a transfusion include:

1. Fever
2. Transfusion reaction which may include kidney failure or anemia
3. Heart failure
4. Hepatitis
5. AIDS (acquired immune deficiency syndrome)
6. Other infections

_____ _____

Printed Name Signature

_____

Date

INFORMED CONSENT FOR OPTIONAL GENETIC and/or GENDER TESTING

PANORAMA® NON-INVASIVE PRENATAL TESTING (NIPT)

Non-invasive prenatal testing (NIPT) uses a blood sample from the mother to analyze DNA from the placenta for certain chromosome conditions that could affect a baby's health. The test may be collected as early as 10-11 weeks gestation. It can also detect fetal gender if desired.

It is especially recommended for high risk pregnancies including the following situations:

- Advanced maternal age — If you are going to be age 35 or older at the time of delivery
- Personal/family history of chromosomal abnormalities -- (parents, children, siblings, aunts, uncles, first cousins)
- Abnormalities of the fetus seen on ultrasound or other positive screening test

This test can be performed any time after 10-11 weeks gestation depending on maternal weight (it is recommended that patients who weigh >180 wait until after 11 weeks gestation for test collection to decrease the risk of no test results due to low fetal fraction). Test results may take 10-14 business days.

Panorama® NIPT is a screening test, meaning that it only determines whether your baby is at increased or decreased risk for these conditions. It cannot detect all genetic changes that could cause health problems. Not all chromosomal abnormalities may be detected, therefore this test does not eliminate the possibility that these or other chromosomal abnormalities may exist in this pregnancy. **A patient with a high-risk test result will be referred for genetic counseling and offered further testing options.**

In rare circumstances, results cannot be obtained. Depending upon a variety of factors, a redraw may or may not be requested. If a redraw is requested, this is done at no additional charge. A repeat sample does not always return a result. Women who do not receive a result from Panorama may be at unchanged or increased risk to be carrying a baby with a chromosome abnormality.

HORIZON® GENETIC CARRIER SCREENING

Genetic carrier screening is a blood test that analyzes your genes to determine whether you are a carrier of certain genetic conditions. Being a carrier puts you at increased risk to have a child affected with a specific genetic disease. Carrier screening helps you better understand your risk of passing on certain inherited diseases. There is no genetic screening test that is 100% predictive or accurate. Carrier screening is an optional voluntary decision. You can choose to have carrier screening, or you can choose not to.

If through carrier screening, you are found to be a carrier of an autosomal recessive genetic condition, then your partner will need to be tested for the same condition to clearly understand your reproductive risks. If you are a carrier of an X-linked condition, each of your pregnancies has a risk of having an affected child.

This office offers single option carrier screening, or screening for multiple options. Some of these disorders occur more often in certain races ethnic groups, but they are not restricted to these groups.

All women are offered carrier screening for cystic fibrosis, spinal muscular atrophy (SMA) and hemoglobinopathies. You may have screening for additional disorders as well. There are two approaches to carrier screening for additional disorders: 1) targeted screening and 2) expanded carrier screening. In targeted screening, you are tested for disorders based on your ethnicity and family history. In expanded screening, many disorders are screened using a single sample, without regard to race or ethnicity. Expanded screening panels usually focus on severe disorders that affect a person's quality of life from an early age.

- **Cystic Fibrosis (CF)** is a condition that causes problems with how the lungs, digestive system, and other parts of the body function. People with CF have delayed growth because of difficulties in digestion and recurrent lung infections that lead to permanent lung damage. Complications of CF can lead to early death. There are treatments for CF that can help lessen the severity of symptoms, but at this time, there is no cure. CF does not affect intelligence. CF is inherited in an autosomal recessive manner, meaning both parents must be carriers of CF for their children to be affected. People who are carriers are typically healthy and do not have CF.

- **Spinal Muscular Atrophy (SMA)** is a serious childhood condition that causes worsening muscle weakness, decreased ability to breathe, and loss of motor skills. Most children with SMA show symptoms in infancy and many die before the age of 2 years. Some children with SMA develop muscle weakness and other symptoms later in childhood. SMA is a leading inherited disease of infant death. SMA is inherited in an autosomal recessive manner. This means that in most cases, both parents must be carriers of an SMN1 gene mutation to have a child with SMA. People who are carriers are generally healthy and do not have SMA, however carriers may have an increased risk of having a child with SMA.

- **Duchenne Muscular Dystrophy (DMD)** is a condition that causes progressive skeletal muscle degeneration. The muscle weakness usually begins around 3-5 years of age and worsens to eventually involve the muscles of the lungs and heart in teenage years. DMD is an X-linked disorder, therefore it is more common for boys to be affected than girls. Children with DMD need lifelong medical treatment and most will be wheelchair bound by their mid to late teenage years. Survival into the 20s and 30s is common with current medical treatments. DMD is an X-linked condition, meaning it is caused by a mutation in a gene on the X chromosome. DMD can be inherited from a mother who is a carrier of a mutation in the DMD gene, however some children born with DMD have a new mutation that is not inherited but happened by chance.
- **Fragile X** Fragile X Syndrome is a common cause of intellectual disability. Boys with Fragile X are usually more severely affected than girls. Symptoms may include behavior problems and symptoms of autism. There is no cure for Fragile X currently. Children with Fragile X often need early intervention and special education, speech therapy, and behavioral therapy. Fragile X is an X-linked condition, meaning it is caused by a mutation in a gene on the X chromosome. Premutation carriers are often healthy and have no symptoms but have an increased risk to have a child with Fragile X. Some premutation carriers are at risk for certain health problems including fertility issues.
- **Alpha and Beta Thalassemia** are blood disorders in which the body makes an abnormal form or inadequate amount of hemoglobin. Hemoglobin is the protein in red blood cells that carries oxygen. The disorder results in large numbers of red blood cells being destroyed, which leads to anemia. There are different levels of severity, but the anemia can be severe or even fatal. About 1 in every 2500 babies are born with either Alpha or Beta Thalassemia.

Natera® offers HORIZON® 14 which includes Cystic Fibrosis, Spinal Muscular Atrophy, Duchenne Muscular Dystrophy, Fragile X, and Alpha and Beta Thalassemia for the same cost to the patient as single testing options. Natera offers other single, targeted, and expanded panels that you may discuss with your physician.

The decision to accept or decline genetic screening is yours. If you would like additional information, you can ask your provider for information on how you can schedule a free, 15-minute information session through Natera® with a certified genetic counselor.

I have read all the above statements and have had the opportunity to discuss genetic screening with my healthcare provider or someone he/she has designated.

____ I consent to Panorama® prenatal screening.

____ I decline Panorama® Non-invasive Prenatal Screening at this time.

____ I consent to Horizon® 14 carrier screening.

____ I consent to only the specified carrier screening: __ CF __ SMA __ DMD __ Fragile X __ Tay-Sachs

__ Other_____

____ I decline all Horizon® Carrier Screening at this time.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date

Please see the Natera® billing information sheet enclosed in your OB packet for further information regarding cost of testing and discount offers.

SNEAKPEEK CLINICAL EARLY GENDER DNA TEST:

SneakPeek Clinical is an early gender DNA detection test offered to women starting at 9 weeks gestation. The blood sample is collected in the office and sent to SneakPeek Labs for testing. Results are available in 2-3 days and will be emailed to the patient directly. SneakPeek utilizes the natural process of shared fetal DNA circulating inside the mother's bloodstream. The technology has the ability to detect the presence or absence of male Y chromosome in the blood sample provided starting as early as 9 weeks into pregnancy. If Y chromosome is detected, then the baby's gender is male and if it is not detected, then the baby's gender is female. The test is 99.1% accurate. **The test does not indicate chromosomal or other abnormalities, ONLY GENDER. The cost is 149.00 and must be paid prior to collection.**

____ **I consent to SneakPeek GENDER ONLY testing.**

____ **I decline SneakPeek GENDER ONLY testing.**

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date