The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Women's Care of Alaska
2741 DeBarr Road, Suite C205
Anchorage, AK 99508
(907) 279-2273 * Fax (907) 258-7705
Wynd Counts, MD * Wendy Cruz, MD
Allison van Haastert, MD * Jessica Goldberger, MD * Meagan Byrne, DO

OBSTETRIC MEDICAL HISTORY

Name:
LAST FIRST MIDDLE

Date Form Completed: – –

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

Personal Health History

1. ☐ Yes ☐ No **Have you ever had an allergic reaction to a medication or vaccine component?**

If yes, please list: _____

Any other allergies or reactions? _____

2. **Please mark any condition that you have or have had in the past:**

- ☐ Epilepsy
- ☐ Headaches
- ☐ Thyroid Disorder
- ☐ Breast Disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Anemia
- ☐ von Willebrand disease or other bleeding disorders
- ☐ Blood Clotting Disorder (eg, Phlebitis/Thrombophilia)
- ☐ Blood Transfusion
- ☐ Gastrointestinal Illness
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Recurrent Urinary Tract Infections
- ☐ Gestational Diabetes
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Arthritis or Lupus
- ☐ Skin Disorders
- ☐ Prior Preterm Birth
- ☐ Group B Streptococcus In Prior Pregnancy
- ☐ Herpes
- ☐ Sexually Transmitted Infections
- ☐ HIV/AIDS
- ☐ Frequent Infections
- ☐ Psychiatric Illness
- ☐ Depression/Postpartum Depression
- ☐ Eating Disorder
- ☐ Other: _____

Describe, if needed: _____

3. **Please indicate any surgery or hospitalization that you have had and the date:**

4. **Please describe any health problems or symptoms that you are having at this time:**

5. ☐ Yes ☐ No **Do you or any family member have a history of problems with anesthesia?**

If yes, please describe: _____

6. ☐ Yes ☐ No **Do you have any objections to any form of medical treatment (eg, blood transfusion)?**

If yes, please describe: _____

Exposures Affecting Health

1. ☐ Yes ☐ No **Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped?**

If yes, how many packs per day? _____ **If former smoker/user, when did you quit?** _____

2. ☐ Yes ☐ No **Do you drink alcoholic beverages now or did you before you became pregnant?**

If yes, please indicate number of drinks per week: _____

What type of drinks? _____

3. **Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines:** _____

_____

4. ☐ **Yes** ☐ **No** **Have you used any street drugs since your last menstrual period (eg, cocaine, marijuana, opioids)?**

If yes, please indicate number of uses per week: _____

What type of drugs? _____

5. ☐ **Yes** ☐ **No** **Do you have any reason to believe you or your partner may have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs?**

6. ☐ **Yes** ☐ **No** **Have you been exposed to chemicals (eg, pesticides, lead, hazardous material/agents) or radiation (eg, X-rays) since you became pregnant? If yes, please describe:** _____

7. ☐ **Yes** ☐ **No** **Are you on a restricted diet?**

If yes, please describe: _____

Gynecologic Health History

1. **When was your last Pap test?** _____

☐ **Yes** ☐ **No** **Have you received all three doses of the HPV vaccine?**

☐ **Yes** ☐ **No** **Have you ever had an abnormal pap test?**

If yes, when and how were you treated? _____

_____

What was the diagnosis? _____

☐ **Yes** ☐ **No** **Have you ever had HPV?**

2. ☐ **Yes** ☐ **No** **Have you ever had** ☐ **Gonorrhea** ☐ **Chlamydia** ☐ **Pelvic Inflammatory Disease**

If yes, when, how, and where were you treated? _____

3. ☐ **Yes** ☐ **No** **Have you ever had herpes?**

If yes, where do you have outbreaks? _____

If yes, how often do you have outbreaks? _____

☐ **Yes** ☐ **No** **Have you ever had syphilis?**

If yes, how, when, and where were you treated? _____

4. ☐ **Yes** ☐ **No** **Have you ever used an intrauterine device (IUD) for contraception?**

If yes, please indicate when: _____

☐ **Yes** ☐ **No** **Did you have any problem with the IUD?**

If yes, please describe: _____

5. ☐ **Yes** ☐ **No** **Have you been treated for infertility?**

If yes, please describe when and treatment received: _____

_____

6. ☐ **Yes** ☐ **No** **Do you have any other concerns related to your past health history?If yes, please list:** _____

_____

W. Counts, MD * W. Cruz, MD * A. van Haastert, MD * J. Goldberger, MD * M. Byrne, DO

Family History & Genetic Screening

1. What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

2. ☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect?

   If yes, please describe: _____

3. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?

   If yes, please describe: _____

4. Please describe any special needs that have occurred in children of your family or the baby's father's family (eg, cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis):

   _____

   _____

   How is this child/person related to you? _____

5. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)?

   If yes, have either of you had genetic counseling? ☐ Yes ☐ No

   If yes, have either of you had chromosomal testing? ☐ Yes ☐ No

   Where and what were the results? _____

6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

   ☐ Yes ☐ No Eastern European Jewish (Ashkenazi) Ancestry

   If yes, have you had tay–sachs screening tests? ☐ Yes ☐ No

   If yes, have you had a canavan screening test? ☐ Yes ☐ No

   If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No

   Date: _____ /_____ /_____ Result: _____

   ☐ Yes ☐ No African American

   If yes, have you had sickle cell screening? ☐ Yes ☐ No

   Date:_____/_____ /_____ Result: _____

   ☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry

   If yes, have you had screening for inherited forms of anemia such as Thalassemia? ☐ Yes ☐ No

   ☐ Yes ☐ No French Canadian or Cajun Ancestry

   If yes, have you had Tay–Sachs screening tests? ☐ Yes ☐ No

7. ☐ Yes ☐ No Have you had cystic fibrosis screening?

8. ☐ Yes ☐ No Have you had any other genetic carrier screening, such as an expanded carrier screening?

   Screening:_____ Date: _____ /_____ /_____ Result:_____

9. Please list any other concerns you have about birth defects or inherited disorders:

   _____

   _____

   _____

10. ☐ Yes ☐ No Do you want a test that will tell you about your risk to have a baby with Down syndrome?

11. ☐ Yes ☐ No Is the father 45 years or older?

Psychosocial Screening*

1. ☐ **Yes** ☐ **No** **Do you have any problems (eg, job, transportation) that prevent you from keeping your health care appointments?**

2. ☐ **Yes** ☐ **No** **Do you feel unsafe where you live?**

3. ☐ **Yes** ☐ **No** **Are you exposed to second-hand smoke?** ☐ **Yes** ☐ **No** **In the past 2 months, have you used any form of tobacco, including smoked, chewed, any type of nicotine delivery system (ENDS), and vaped?**

4. ☐ **Yes** ☐ **No** **In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?**

5. ☐ **Yes** ☐ **No** **In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?**

6. ☐ **Yes** ☐ **No** **Has anyone forced you to perform any sexual act that you did not want to do?**

7. **On a 1–5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High**

8. **How many times have you moved in the past 12 months?** _____

9. **If you could change the timing of this pregnancy, would you want it** ☐ **earlier** ☐ **later** ☐ **not at all / NA**

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

_____

PATIENT SIGNATURE

_____

PRINT NAME

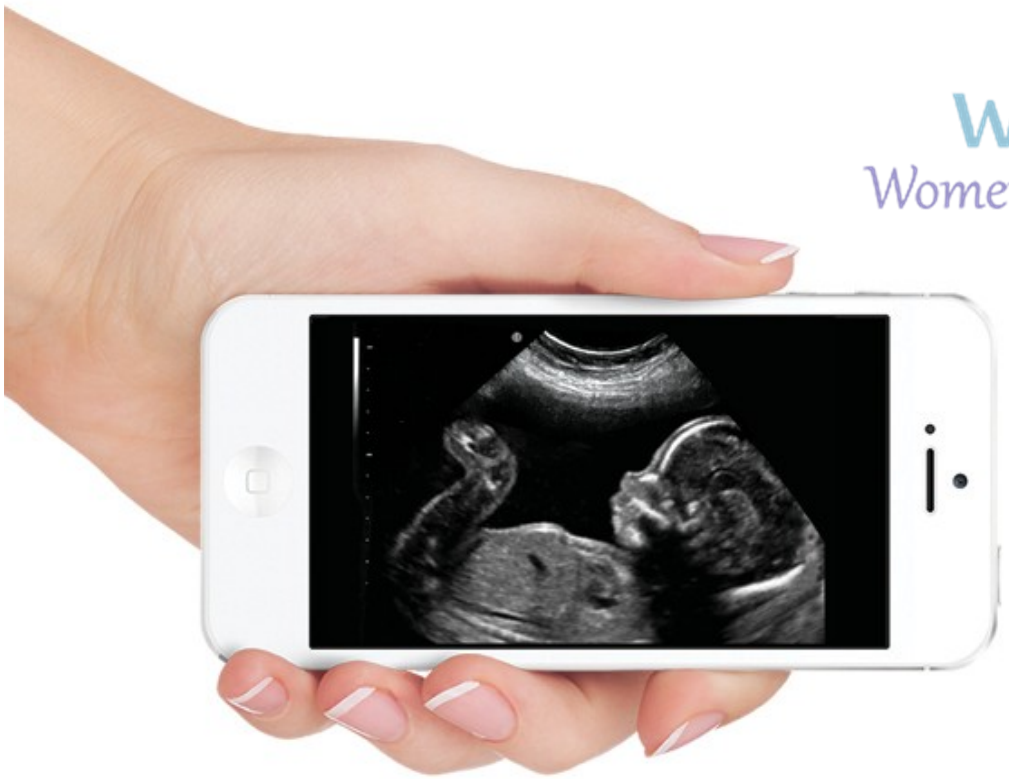
_____

DATE

Notes

Tricefy™ your ultrasound at

WC AK
Women's Care of Alaska



☐ I want my ultrasound images delivered digitally as an email or text.

Email Address: _____

Mobile Phone Number: (_____)_____

☐ I authorize the sending of images during my pregnancy.

☐ I have read, understand, and agree to this disclaimer.

Name: _____

Signature: _____ Date: _____

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After you complete and sign this Agreement, a mobile telephone number or email address you designate will be entered into our ultrasound system and re-verified with you. When your ultrasound screening is complete, in accordance with your provider's policies and procedures, the sonographer will trigger the ultrasound machine to send an encrypted copy of your examination to the Tricefy™ server. The server will reformat and encrypt the file and provide access to the examination through your mobile phone number and a text or email. The physician will have the discretion to determine whether your ultrasound screening is complete and whether to transmit your images to Tricefy™. The Physician has the right to refuse to transmit or to delay the transmission of your images. Both the text and email message will contain secure links and instructions on how to access the images. Images and videos can be accessed and downloaded to your mobile phone and computer.

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