

**ASSOCIATED
VALLEY OBSTETRICS AND GYNECOLOGY**

Talbot Professional Center • 4011 Talbot Road South – Suite 430 • Renton, Washington • (425) 656-2496

PATIENT REGISTRATION

PATIENTNAME _____ TODAY'S DATE _____

Address _____ Home Phone _____

_____ Cell Phone _____

City/State/Zip _____ Work Phone _____

Is it ok to leave messages on your answering machine? _____

Patient's relationship to person responsible for bill: Self Spouse Child Dependent Marital Status: S M W D

Birthdate _____ Age _____ Sex: Male Female Soc Sec # _____

How did you hear about our office? Insurance Book _____ Yellow Pages _____ Friend _____ Other _____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER _____ SPOUSE'S NAME _____

Address _____ Spouse's Employer _____

_____ Spouse's Work Phone _____

Occupation _____ Spouse's Soc Sec # _____ Birthdate _____

PERSON RESPONSIBLE FOR BILL IF NOT PATIENT

NAME _____ EMPLOYER _____

Address _____ Address _____

Home Phone _____ Work Phone _____ Occupation _____

INSURANCE INFORMATION

Primary Insurance Name _____ Secondary Insurance Name _____

Subscriber's Name _____ Birthdate _____ Subscriber's Name _____ Birthdate _____

Group # _____ ID # _____ Group # _____ ID # _____

Address _____ Address _____

Phone # _____ Phone # _____

Patient's relationship to subscriber: Self Spouse Child Dependent Relationship to subscriber: Self Spouse Child Dependent

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED (NOT LIVING AT SAME ADDRESS)

Name _____ Relationship to patient _____

Home Phone _____ Work Phone _____ Other _____

ASSIGNMENT AND RELEASE

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I also understand that I will be charged a service charge of 1% per month (12% annually) on any amount outstanding 60 days past due.

SIGNED: _____

AUTHORIZATION OF TREATMENT OF A MINOR: I authorize Valley OB/GYN to treat the minor patient named above. It is our policy that the parent or guardian who requests treatment of a minor be financially responsible for the services rendered.

SIGNED: _____

NOTICE OF PRIVACY PRACTICES- ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting The Office Manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

May we leave a message on your home recorder? YES ___ NO ___

May we leave a message with people at your house? YES ___ NO ___

May we discuss your test results with members at your house? YES ___ NO ___

Please list family members with whom we may discuss test results.

Name _____

Name _____

By my signature below I acknowledge acceptance of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian,
personal representative)

OB Guidelines

COURSE OF PRENATAL CARE

You will have approximately 14 doctor visits during your pregnancy. Typically your appointments are every 4 weeks until 30 weeks, every 2 weeks until 36 weeks, then weekly until your delivery.

LAB WORK DURING PREGNANCY

INITIAL LABS WILL BE DRAWN AT YOUR NURSE VISIT AND INCLUDE

Complete blood count

Hepatitis B

HIV

RPR (a required test for Syphilis)

Rubella

Urine Analysis

Thyroid and blood sugar levels are optional depending on your physicians preference

At your initial doctors appointment you will be given written information on cystic fibrosis screening and a specialized prenatal risk screening (called an integrated screen) that includes a 1st trimester ultrasound combined with bloodwork, and follow up bloodwork during the 2nd trimester. These tests are optional.

16-22 weeks

Prenatal Risk Screen (Quad Screen)—Assesses your risk for having a baby born with birth defects and combines blood values with your medical history to produce the result.

Early diabetes screening—May be done if you have history of gestational diabetes with a previous pregnancy.

18 – 20 weeks

Ultrasound— A detailed anatomical scan is done at this time. Hopefully you can find out the sex at this time if you choose and the baby cooperates.

28 weeks

Gestational Diabetes Screen

Rhogam injection if you have an Rh negative blood type

Pre register for the hospital

36 weeks

Group B Strep Culture

Weight Gain

Recommended weight gain is 25 – 30 lbs.

Lifting limit

30 – 40 lbs

Nutritional Recommendations

- 8 – 10 glasses of water/ day—This is about 1 glass per hour while awake. Important because of increased risk for urinary tract infections, and kidney stones. Also, being dehydrated may increase your risk to have preterm contractions.
- 1200 mg of calcium= 4 glasses of milk or dairy servings or 2 Tums EX
- Add 300 calories to your daily diet
- Refer to page 114 of your OB book for detailed explanation of nutritional recommendations.
- Not more than 2 servings of caffeine/day if desired.

Nausea and Vomiting

- Try to eat small amounts frequently throughout the day. If you are unable to eat during the early part of the pregnancy you will make up the difference in the 2nd and 3rd trimester.
- Sip liquids constantly—The most important thing is to **stay hydrated**. If vomiting is continuous be sure to call!
- Vitamin B6 50 mg 2 or 3 times/day up to 200 mg. may be helpful. This is over the counter at your pharmacy.

Approved over the counter medications

- Tylenol (extra strength)—use as directed on the bottle.
NO ASPIRIN OR IBUPROFEN
- Cold medications—Sudafed, Tylenol Sinus, Tylenol Cold, Benadryl, Tylenol PM, Chlortrimetron, Robitussin CF, Claritin, Throat lozenges
- Tums, Mylanta, Maalox, Prevacid, Zantac, Pepcid

Dental Work

- Ok with local anesthesia only—no nitrous gas
- XRay's ok with lead shield.

Call the office for the following:

- Vaginal bleeding
- Fluid leaking from vagina
- Temp over 101

*****NO ALCOHOL, NO SMOKING*****

No hot tubs, No saunas



Associated Valley Obstetrics & Gynecology

Dear Mother-To-Be:

KATHLEEN J. HANLON, M.D.
Board Certified in
Obstetrics and Gynecology

PATRICIA F. KEEGAN, M.D.
Board Certified in
Obstetrics and Gynecology

ALISON L. WEBB, M.D.
Board Certified in
Obstetrics and Gynecology

LORI D. CHANNELL, M.D.
Board Certified in
Obstetrics and Gynecology

KELLY D. COLE, M.D.
Board Certified in
Obstetrics and Gynecology

MOLLY T.H. OXFORD, M.D.
Board Eligible in
Obstetrics and Gynecology

TALBOT PROFESSIONAL CENTER
4011 TALBOT RD. S. SUITE 430
RENTON, WA 98055

PHONE (425) 656-2496

FAX (206) 575-2616

Welcome to Valley Obstetrics and Gynecology! We look forward to our association during this important time. We are a four physician practice. During the course of your obstetrical care, we will try to have you meet all of us so that you may have the opportunity to discuss your desires and ask questions. Our group of physicians share "after hours" call during the week. On holidays and weekends we share call with another OB specialty practice, which means that you may speak with or be delivered by someone other than your chosen physician.

During your initial OB visits we will draw blood for lab studies to find out your blood type, blood count, and whether you are immune to German measles or have any irregular blood antibodies. In addition, we recommend testing for other conditions which could be dangerous for the pregnancy if unrecognized. These include: gonorrhea, chlamydia, hepatitis, syphilis, and human immunodeficiency virus (AIDS virus). You may also have a pap smear. Results of all these tests will be shared with you as they are returned from the laboratory. These lab results cannot be made available to anyone outside this office without your written consent. This policy is to ensure protection of your privacy.

At 16 weeks of gestational age, we recommend drawing a blood test called *alpha fetoprotein* which is a screening test for spinal cord defects such as spina bifida. You may also choose to have a test called a *prenatal risk profile* which calculates an individual's risk for Down Syndrome. Although these are good screening tests, a normal result does not guarantee that your baby will not have any of these problems.

We also offer you ultrasound exams of your infant, usually performed at 8 weeks and approximately 16 to 20 weeks gestation. These tests are done to confirm your due date and to look for any abnormalities in your infant. While this is an excellent test, not all anomalies are detectable with ultrasound. Ultrasound is also used for medical evaluations when there is bleeding, poor fetal growth, or decreased fetal movement. Ultrasound is used extensively across the country and has not been associated with any later abnormalities in children.

If the above presented plan of care is acceptable to you, please note your approval by signing the line below. If for any reason, you question or decline any part of this plan, please place your initials in the margin near the item in question. We encourage you to let us know of any questions or concerns you may have throughout your pregnancy. Our nurses can answer many of your questions by phone, or if necessary they will defer to one of the physicians for more extensive medical problems.

The entire staff including physicians, the clinical nursing staff, and business office personnel have as our goal the expedient, courteous, and professional care of you and your infant during this important time.

Again, welcome to Valley Obstetrics and Gynecology.

Signature of Acceptance _____ Date _____

Name Printed _____

ASSOCIATED
VALLEY OBSTETRICS & GYNECOLOGY Inc., P.S.

KATHLEEN J. HANLON, M.D., F.A.C.O.G.
 PATRICIA F. KEEGAN, M.D., F.A.C.O.G.
 ALISON L. WEBB, M.D., F.A.C.O.G.
 LORI D. CHANNELL, M.D., F.A.C.O.G.
 KELLY D. COLE, M.D., F.A.C.O.G.
 MOLLY T.H. OXFORD, M.D.

TALBOT PROFESSIONAL CENTER • 4011 TALBOT RD. S. • SUITE 430 • (425) 656-2496 FAX (206) 575-2616

Appointment with Dr. _____

NAME	AGE	ETHNIC	RELIGION	OCCUPATION	HT.	WT.
Patient						
Father of Baby						

Marital Status _____

TOTAL PREG.	FULL TERM	PREMATURE	MISCARRIAGE	ELECIVE ABORTION	LIVING CHILDREN

Last period began _____

Previous period began _____

Age periods started _____

How often are your periods? _____ days

Normal length of flow _____ days

Last form of contraception _____ When stopped _____

Is this a planned pregnancy? YES NO

Type of pregnancy test? HOME OFFICE When? _____

Any spotting or bleeding since you became pregnant? _____

Last PAP smear? _____ Abnormal? _____

PAST MEDICAL HISTORY

Your birth weight _____

Medical problems _____

Surgeries _____

Medications _____

Allergies _____

Transfusions _____

Have you ever had an infection in your uterus, tubes, or ovaries? _____

FAMILY MEDICAL HISTORY

Has anyone on either side of your families been born with a congenital or genetic disorder? _____

Does anyone have diabetes, heart disease, cancer, etc.? _____

DAILY LIVING

Do you drink coffee, tea, or cola? NO YES _____ per day

Do you smoke cigarettes? NO YES _____ per day

How much alcohol do you drink? _____ per day _____ per week

Have you or do you use marijuana? _____

Have you or do you use cocaine, uppers, or downers? _____

What is your exercise routine? _____

Have you emptied your cat's litter box or worked in a garden a cat would use for litter since pregnant? NO YES

OBSTETRIC HISTORY (Starting with your oldest child)

Name					
Sex					
Birth Date					
Birth Weight					
Early or Late?					
How long was labor?					
C-section or vaginal delivery?					
How long did you push?					
Forceps/vacuum?					
Episiotomy?					
Anesthesia?					
Your weight gain?					
Complications?					
Breast feed? How long?					
Is your child healthy?					
If a boy, is he circumcised?					

PRENATAL GENETIC INFORMATION AND QUESTIONNAIRE

Having a healthy baby is a special event. Once a baby is born, families take certain precautions to ensure the baby's health and safety. The unborn child deserves similar care. While most babies are born healthy, some babies can be born with a birth defect or develop a significant health problem after birth. Many of these problems occur despite the best prenatal care; however, some birth defects can be prevented, or at least detected, before birth with appropriate screening.

THE MSAFP SCREENING TEST

Before birth, all babies make a substance called alpha-fetoprotein (AFP). Small amounts of AFP pass into the amniotic fluid around the baby. A smaller amount of AFP crosses the placenta into the mother's blood. This is called maternal serum AFP, or MSAFP.

The MSAFP test is a blood test done on the mother at 16-19 weeks of pregnancy. It is done to find pregnancies that may have a higher chance for problems. The MSAFP test can find babies with certain defects of the brain or spinal cord called neural tube defects. In the Northwest, 1-2 of every 1,000 babies has a neural tube defect. If a baby has an open neural tube defect, very high levels of AFP may be in the amniotic fluid and in the mother's blood. When the MSAFP test is done on the mother, about 8 or 9 out of every 10 babies with open neural tube defects can be found.

Most abnormal MSAFP test results are not due to babies with neural tube defects. Most high and low MSAFP levels occur when the baby is normal but the pregnancy has been given the wrong due date. About half of twins may be found with high MSAFP levels. High MSAFP values are also found in mothers at risk for low birthweight babies and certain other problems that require special care. Very low MSAFP values have been found in mothers with babies with chromosome abnormalities, such as Down's Syndrome.

The MSAFP test is just a screening test. Its purpose is to find pregnancies that might have a higher chance for problems. The test can cause extra worry if it is not understood. It is important to know that 5-10 of every 100 women tested will have an abnormal MSAFP. This does not mean the baby has problems. It only means that more testing should be done. Remember, most abnormal test results are caused by wrong due dates. In these cases, the only extra test needed is an ultrasound.

If you would like to have this blood test done, or would like more information, talk to your health care provider.

QUESTIONNAIRE

In addition to the MSAFP screening test, the following questionnaire is designed to help determine if there are any problems in your family (or the family of the baby's father) which should be discussed and/or further evaluated. Please answer the questions as accurately as possible. All answers will remain private. If you are unsure of a specific question, please discuss it with your health care provider. The first questions relate to your family history. When thinking about your families (yours and the baby's father's), please include your child (or unborn baby), mother, father, sisters, brothers, grandparents, aunts, uncles, nieces, nephews or cousins.

- Yes No 1. Will you be 35 years or older when the baby is due? Age when due _____.
- Yes No 2. Are you and the baby's father related to each other (i.e. cousins)?
- Yes No 3. Have you had three or more pregnancies that ended in miscarriage?
- Yes No 4. Have you or the baby's father had a stillborn baby or a child who died around the time of delivery?
- Yes No 5. Have you or the baby's father had a child with a birth defect, genetic condition, or mental retardation?
- Yes No 6. Do either you or the baby's father have a birth defect or genetic condition such as a baby born with an open spine (spina bifida), a heart defect, or Down's Syndrome?
- Yes No 7. Does anyone in your family or anyone in the baby's father's family have a birth defect or condition that has been diagnosed or inherited, such as open spine (spina bifida), a heart defect, or Down's Syndrome?
- Yes No 8. Where your ancestors came from may give us important information about the health of your baby. Are you or the baby's father from any of the following ethnic/racial groups: Jewish, Black, Asian, or Mediterranean (Greek, Italian)?
- Yes No 9. Have you or the baby's father ever been screened to see if you are carriers of the gene for any of the following: Tay-Sachs, Sickle Cell, Thalassemia?

Sometimes, the unborn baby can be exposed to outside factors that can cause birth defects. The next questions will give us important information about possible exposure to the baby.

- Yes No 10. Have you had any x-rays during this pregnancy?
- Yes No 11. Have you taken any over-the-counter, prescription, or "street" drugs during this pregnancy such as seizure medications, anti-cancer drugs, anticoagulants (blood thinners), lithium, or accutane? If yes, list drugs: _____
- Yes No 12. Have you had any alcohol during this pregnancy?
13. Prior to your pregnancy, how often did you drink alcoholic beverages?
- | | |
|---|--|
| <input type="radio"/> Every day | <input type="radio"/> Less than once a month |
| <input type="radio"/> At least once a week, not daily | <input type="radio"/> I do not drink alcoholic beverages |
| <input type="radio"/> At least once a month, not weekly | |

PATIENT NAME

Patient Signature

Date

14. Prior to your pregnancy, about how many alcoholic beverages did you usually have per occasion? (1 = one can of beer, one wine cooler, one glass of wine, or one shot of liquor.)
- 3 or more
 - 1 to 2
 - I do not drink alcoholic beverages

Yes No 15. Have you ever sought and/or received treatment for alcohol or drug problems? If yes, how long ago? _____

Yes No 16. Do you think you are at increased risk of having a baby with a birth defect or genetic disorder?

Yes No 17. Have you had a fever of 103°F or greater, or a rash, at any time during the first two months of your pregnancy?

Yes No 18. Have you or the baby's father ever had hepatitis or yellow jaundice?

A test for HIV is strongly recommended for all pregnant women, regardless of your responses to the next questions. The test is voluntary. There are two reasons to be tested: [1] New medications are available to reduce the chance of an infected mother passing HIV to her baby; and [2] Most women do not know they are infected with HIV until late in the disease. Sometimes, other infections can put you and your baby at risk. The following questions will help your health care provider determine other areas for counseling and evaluation.

Yes No Unsure 19. Have you or your sexual partners ever had a sexually transmissible disease (STD or VD) such as syphilis, gonorrhea, chlamydia or herpes?

Yes No Unsure 20. Have you ever had a serious pelvic infection, or pelvic inflammatory disease (PID)?

Yes No Unsure 21. Do you think any of your male sexual partners have ever had sex with other men?

Yes No Unsure 22. Have you or your sexual partners ever used IV street drugs?

Yes No Unsure 23. Have you had sex with two or more partners in the last twelve months?

Yes No Unsure 24. Do you think any of your sexual partners may have HIV or AIDS?

Yes No Unsure 25. Have you or your sexual partners ever had a blood transfusion?

How safe you feel in your daily living gives us important information about risks to you and your baby. Please answer these questions as well as you can. All answers will remain private.

26. Do you feel safe

Yes No - in your personal relationship?

Yes No - within your home?

Yes No - in your own neighborhood?

Yes No - other (specify) _____

Yes No 27. Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced other kinds of hurting?

Yes No 28. Are you being or have you ever been hit, slapped, kicked, pushed or otherwise physically hurt? If yes, by whom?

Husband

Family Member

Ex-husband

Stranger

Partner

Other (specify) _____

Yes No 29. Are you experiencing or have you ever experienced uncomfortable touching or forced sexual contact? If yes, by whom?

Husband

Family Member

Ex-husband

Stranger

Partner

Other (specify) _____

GENETIC COUNSELING CENTERS

SEATTLE

Children's Hospital & Medical Center (206) 526-2056
Genetic Diagnosis and Counseling

Columbia Health Center (206) 587-4650
Genetic and Prenatal Diagnosis and Counseling

Seattle Group Health Cooperative of Puget Sound
(Group Health members only)
Genetic and Prenatal Diagnosis and Counseling
(425) 883-5625

Swedish Hospital & Medical Center (206) 386-2101

Prenatal Diagnosis and Counseling

University of Washington
Genetic Diagnosis and Counseling (206) 548-4030
Prenatal Diagnosis and Counseling (206) 543-3753

TACOMA

Mary Bridge Children's Health Center Genetics Clinic
Genetic and Prenatal Diagnosis and Counseling
(253) 594-1415

PATIENT NAME

Patient Signature

Date

