# SAVANNAH OB/GYN, PC


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Welcome to Savannah OB/GYN, P.C. We're glad you've chosen our practice to receive your obstetrical care.

This is to confirm that _____ has an appointment with

_____ on _____ at _____.

If the date or time for the appointment does not work well with your schedule, please give our office a call. Our office requires a 24 hour notification if you are not going to be able to make it to your scheduled appointment; or you could be charged a $25 No Show fee.

**Please arrive 30 minutes early** to your appointment in order to ensure that your information is entered into our system in a timely manner. If you are more than **15 minutes late** for your appointment, we may work you in as the schedule permits or reschedule the appointment for another day. Also, please call if you think you are going to be late for your visit so that we can adjust the schedule accordingly.

To insure speedy check in time, we ask our new patients to do the following:

1. Please fill out the enclosed new patient information packet and bring it with you to your appointment.
2. Please bring your **insurance cards,** a **picture ID,** and a **current list of meds.**
3. If you are a transfer patient, please bring any medical records from your previous doctor. If you are having difficulties trying to obtain your medical records, please notify our office prior to your appointment.
4. Please be on time to your appointment, and remember that your first visit with us may take longer than your follow up appointment, please allow for this in your schedule.
5. **PLEASE COMPLETE ALL SECTIONS OF THIS PAPERWORK PRIOR TO YOUR APPOINTMENT.**

Again, thank you for electing to see one of our healthcare providers and we hope your experience with our office will be very pleasurable. If you have any questions or concerns, please feel free to call us.

Savannah OB/GYN, P.C.

# PATIENT REGISTRATION

Last Name: _____ First Name _____ MI _____

SSN: _____ Sex: _____ Date of Birth _____/_____/_____ Marital Status _____

Address _____ APT _____

City _____ State _____ ZIP _____

Home #_____ Work #_____ Cell #_____

Email _____ Primary Care Physician _____

Employer _____

Employer's Address _____

**IF PATIENT IS A MINOR OR DEPENDENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:**

Responsible Party _____ Relation to Patient _____

Home #_____ Work #_____ Cell #_____

**PRIMARY INSURANCE (A COPY OF YOUR INSURNACE CARD IS REQUIRED)**

Insurance _____ ID _____ Group _____

Insured's Name _____ Insured's Date of Birth _____/_____/_____

Social Security Number _____ Relation to Patient _____

Employer Name _____

**SECONDARY INSURANCE (A COPY OF YOUR INSURNACE CARD IS REQUIRED)**

Insurance _____ ID _____ Group _____

Insured's Name _____ Insured's Date of Birth _____/_____/_____

Social Security Number _____ Relation to Patient _____

Employer Name _____

**EMERGENCY CONTACT**

Name _____ Relation to Patient _____

Home #_____ Work #_____ Cell #_____

**CONSENT FOR TREATMENT**

The signature below serves as consent for services/treatment/referrals to be rendered by Savannah OB/GYN for the above named patient. This also authorizes the practice to release or receive protected health information for the purpose of treatment, payment, or health care operations necessary for such services.

_____ _____

Patient (or legal guardian) signature Date

_____ _____

If legal guardian, print name Relation to patient

**Name:** _____ **Date of Birth:** _____

**Savannah OB/GYN, PC**

This is a confidential record of your medical history and will be kept secure in this office. Information contained here will not be released to any person except when you have authorized us to do so.

**Current Pharmacy:** _____

**Reason for Visit:** _____

**Medical History** – Please indicate if you have any of the following medical conditions, even in the past. If you answer "yes", please tell us who your doctor was and where you were treated.

| | | | |
|---|---|---|---|
| Epilepsy/Seizure Disorder | Yes ☐ No ☐ | Joint Pain/Injury | Yes ☐ No ☐ |
| Migraine Headache | Yes ☐ No ☐ | Breast Biopsy/Lumpectomy | Yes ☐ No ☐ |
| Cluster Headache | Yes ☐ No ☐ | Breast Cancer | Yes ☐ No ☐ |
| Seasonal Allergies/Sinus Infection | Yes ☐ No ☐ | Rheumatoid Arthritis | Yes ☐ No ☐ |
| Asthma | Yes ☐ No ☐ | Lupus | Yes ☐ No ☐ |
| Bronchitis | Yes ☐ No ☐ | Autoimmune Disorder (other) | Yes ☐ No ☐ |
| Pneumonia | Yes ☐ No ☐ | Clotting Disorder | Yes ☐ No ☐ |
| Stroke | Yes ☐ No ☐ | Easy Bruising | Yes ☐ No ☐ |
| Blood Clot (DVT or PE) | Yes ☐ No ☐ | Sickle Cell Disease | Yes ☐ No ☐ |
| Heart Attack | Yes ☐ No ☐ | Anemia | Yes ☐ No ☐ |
| High Blood Pressure | Yes ☐ No ☐ | Chicken Pox | Yes ☐ No ☐ |
| High Cholesterol | Yes ☐ No ☐ | Blood Transfusion | Yes ☐ No ☐ |
| Heartburn/GERD | Yes ☐ No ☐ | Diabetes | Yes ☐ No ☐ |
| Gallbladder Disease | Yes ☐ No ☐ | Thyroid Disorder | Yes ☐ No ☐ |
| Liver Disease | Yes ☐ No ☐ | Other Endocrine Disorder | Yes ☐ No ☐ |
| Hepatitis | Yes ☐ No ☐ | Rheumatic Fever | Yes ☐ No ☐ |
| Chrohn's or Ulcerative Colitis | Yes ☐ No ☐ | Tuberculosis | Yes ☐ No ☐ |
| Constipation | Yes ☐ No ☐ | Other Infectious Disease | Yes ☐ No ☐ |
| Diverticulitis | Yes ☐ No ☐ | Depression | Yes ☐ No ☐ |
| Kidney Disease | Yes ☐ No ☐ | Bipolar Disorder | Yes ☐ No ☐ |
| Kidney Stones | Yes ☐ No ☐ | Anxiety | Yes ☐ No ☐ |
| Frequent UTIs (>3 per year) | Yes ☐ No ☐ | ADHD/ADD | Yes ☐ No ☐ |
| Arthritis | Yes ☐ No ☐ | Substance Abuse/Alcoholism | Yes ☐ No ☐ |
| Chronic Back Pain | Yes ☐ No ☐ | Eating Disorder | Yes ☐ No ☐ |
| Irritable Bowel Syndrome | Yes ☐ No ☐ | Glaucoma | Yes ☐ No ☐ |
| Nausea | Yes ☐ No ☐ | Frequent Sore Throat | Yes ☐ No ☐ |
| Vomiting | Yes ☐ No ☐ | Burning in Urination | Yes ☐ No ☐ |
| Diarrhea | Yes ☐ No ☐ | Frequent Urination | Yes ☐ No ☐ |
| Vomiting Blood | Yes ☐ No ☐ | Blood in Urine | Yes ☐ No ☐ |
| Shortness of Breath | Yes ☐ No ☐ | Urgency/Leak of Urination | Yes ☐ No ☐ |
| Chest Pain | Yes ☐ No ☐ | Herpes | Yes ☐ No ☐ |
| Palpitations (heart races) | Yes ☐ No ☐ | Sexually Transmitted Diseases | Yes ☐ No ☐ |

Please explain "yes" answers in detail along with treating physician, or add conditions not listed:

_____

_____

_____

Name: _____ Date of Birth: _____

**ALLERGIES/SENSITIVITIES** – Please list your allergies to medications, food or other substances, including reaction:

| Substance/Medication | Reaction | Date |
|---|---|---|
| | | |
| | | |
| | | |

**ANESTHESIA** – Do you or any family member have a history of problems with anesthesia? *YES ☐ NO ☐

*If yes, please describe: _____

**SURGICAL HISTORY** – Please list any surgeries you have had along with the date and the name of the doctor who preformed the surgery. (For example: appendectomy, cesarean delivery, knee surgery, etc.)

| Date/Year | Surgery | Reason preformed/Diagnoses | Surgeon |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**MEDICATIONS** – Please provide a complete list of all your medication, vitamins, and dietary supplements including dose:

| Date Started | Med/Vitamin/Supplement | Dose | Prescribed by: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Name: _____ Date of Birth: _____

**MENSTRUAL AND GYNECOLOGIC HISTORY:**

1. How old were you when you first started your period? _____
2. What was the first day of your last menstrual period (if unsure, best guess)? _____
3. Duration of period/bleeding: _____ days
4. Time in between cycles: _____ days
5. Are you currently using a method of birth control? *YES ☐ NO ☐

   If yes, what method(s)? _____
6. Bleeding or spotting between periods? YES ☐ NO ☐
7. Have you had problems with any of the following during your periods in the past (circle all that apply)?

   Heavy Bleeding  Passing Clots  Painful Periods  Irregular Periods

   Skipping Periods  Mood Swings  Irritability  Unable to preform normal tasks

   Other: _____
8. Sexually Transmitted Disease? *YES ☐ NO ☐

   * If yes, were you ever hospitalized or followed up? _____
9. Infertility or difficulty getting pregnant? *YES ☐ NO ☐

   *If yes, please explain: _____

**SOCIAL:**

Primary Language Spoke: _____

Significant Others Name: _____

Are you currently sexually active? YES ☐ NO ☐

Have you ever/currently experiencing: Sexual Abuse Physical Abuse Emotional/Verbal Abuse

How many times a week do you exercise? _____

Do you have an indoor OR outdoor cat? _____

**DIAGNOSTIC STUDIES/SCREENING** – Please indicate if you have had any of the following health screening. If yes, please tell us the date, why the test was done, and the results:

| | | Date | Reason for test | Results | Physician |
|---|---|---|---|---|---|
| DEXA (Bone Density) Scan | YES ☐ NO ☐ | | | | |
| Cholesterol (Lipid Panel) | YES ☐ NO ☐ | | | | |
| Colonoscopy | YES ☐ NO ☐ | | | | |
| Mammogram | YES ☐ NO ☐ | | | | |
| Pap Smear | YES ☐ NO ☐ | | | | |
| Other: _____ | | | | | |

**VACCINATION HISTORY** – Please circle which vaccines you have received and date, if known:

| | | | | |
|---|---|---|---|---|
| Hepatitis A | Hepatitis B | Cervarix | Measles/Mumps/Rubella | H1N1 Flu |
| Tetanus | Chicken Pox | Pneumovax | Pertussis | Other _____ |
| Meningitis | Zostavax (Shingles) | Seasonal Flu | Gardasil | |

**OBJECTIONS** – Do you have any personal or religious objections to any form of medical treatment (i.e. refusal of blood transfusion)? *YES ☐ NO ☐

*If yes, please describe: _____

_____

**OBSTETRICAL HISTORY**:

Total Pregnancies: _____ Full-Term Pregnancies: ___ Premature: _____ Abortions: _____
Miscarriages: _____ Ectopic: _____ Multiple Births: _____
How many living children do you have? _____
Will you be 35 years or older at the time this baby is born? YES ☐ NO ☐

**PREVIOUS PREGNANCIES:**

| Date | Weeks Gestation | Type of Delivery | Health of Child | Complications |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**PERSONAL HISTORY:**

1. Do you smoke? YES ☐ NO ☐
   a. How many years have you been smoking? _____
   b. How much per day? _____
2. Do you drink alcohol? YES ☐ NO ☐
   a. How much per week? _____
3. Are you allergic to any drugs? YES ☐ NO ☐
   a. If yes, which ones? _____

**FAMILY HISTORY** – Does anyone in your family have the following medical conditions? Please circle yes or no and indicate who has the illness and their age at diagnosis if known.

| | | Mother | Father | Bro/Sis | Other |
|---|---|---|---|---|---|
| Ovarian Cancer | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Uterine Cancer | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Breast Cancer | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Colon Cancer | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Cancer(s) | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Attack | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Blood Clot (DVT or PE) | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Inflammatory Bowel Disease | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy/Seizures | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | Yes ☐ No ☐ | ☐ | ☐ | ☐ | ☐ |

**FAMILY GENETICS HISTORY (CONTINUED)** – This pertains to both patient and the father of the baby and his family.

Have you had a child born with a birth defect? YES ☐ NO ☐

*If yes, please describe: _____

Did either you or the baby's father have a birth defect? YES ☐ NO ☐

*If yes, please describe: _____

Please describe any abnormalities that have occurred in the children of your family or the baby's father's family (birth defect, mental handicaps, inherited disease such as hemophilia, muscular dystrophy, or cystic fibrosis:

_____

_____

_____

Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn?) YES ☐ NO ☐

*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? _____

**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:**

1. **Eastern Europe Jewish Ancestry:** Mother ☐ Father ☐ Both ☐

   If yes, have you had Tay-Sachs screening test? YES ☐ NO ☐

   If yes, have you had a Canavan Screening test? YES ☐ NO ☐

   Date: _____ Result: _____

2. **African American**: Mother ☐ Father ☐ Both ☐

   If yes, have you had sickle cell screening? YES ☐ NO ☐

   Date: _____ Result: _____

3. **European Ancestry:** Mother ☐ Father ☐ Both ☐

   If yes, have you had cystic fibrosis screening? YES ☐ NO ☐

4. **Mediterranean Ancestry:** Mother ☐ Father ☐ Both ☐

   If yes, have you had screening for inherited forms of anemia such as thalassemia? YES ☐ NO ☐

# ATTENTION TO OB PATIENTS:

This is to inform you that some insurance companies do not consider ultra-sounds during pregnancy as medically necessary or limit the number that will be covered during your pregnancy. We cannot anticipate what each plan may cover. It is your responsibility to check you benefits and understand that you are not responsible for anything your insurance does not cover.

_____ _____

Patient Signature Date

# CONSENT TO ADMINISTER HIV TEST

I, _____, am a patient of Dr. _____.

This physician has informed me that he/she recommends that I receive an HIV blood test in order to facilitate my treatment as well as to protect hospital personnel and other patients.

I have received counseling prior to my entering into consent for this procedure and have been informed that I have the right to refuse this testing. The counseling I have received from my physician consisted of the following:

_____ Information regarding AIDS and HIV. I have received an explanation of behaviors that reduce the risk of transmitting AIDS and HIV, an explanation of the confidentiality of information regarding both social and medical implications of HIV testing and disclosure of commonly recognized treatment or treatments for AIDS and HIV or literature that explains this to me.

I understand that I will be notified of the result of the HIV test and results will be explained to me:

On the basis, I DO ☐ DO NOT ☐ authorize Savannah OB/GYN, P.C., Dr. _____ or anyone authorized by them to preform the HIV blood test.

_____ _____

Date Signature of Patient

_____ _____

Date Witness

_____ _____

Date Physician

# Medications Safe to Use During Pregnancy

***Headache, Fever**: Plain Tylenol (Acetaminophen)*

***Antacids:** Tums, Mylanta, Axid, Tagamet, Zantac, Pepcid (2nd & 3rd trimesters only)*

***Constipation**: Increase in fiber (eating fruits, green leafy veggies, bran cereals) increase fluid intake, decrease sugars, increase physical activity – if not effective: Colace stool Softener, Metamucil, Benefiber, Citrucel, Miralax, Glycerine Suppository, Prune Juice*

***Diarrhea**: pepto-Bismol, Imodium AD (only 3 days)*

***Hemorrhoids**: Preparation H, Anusol cream and suppositories, Witch Hazel pads*

***Yeast Infection**: Monistat (Miconazole) **Call if no improvement in 2 days***

***Nausea**: Motion Sickness wrist bracelets (Can be purchased at Bass Pro Shops), Ginger, flattened coca cola, Vitamin B6+ Unisom sleep aid, Dramamine, Benadryl*

***Rashes**: Benadryl cream, Hydrocortisone cream/ointment, Caladryl lotion, Aveeno oatmeal bath*

***Allergies**: Claritin D, Zyrtec*

***Sinus Pain and Pressure**: Plain Sudafed, Nasal Saline nose drops, Netti Pot (purchase at pharmacy), Afrin nasal spray (after 12 weeks – once every 12 hours for no more than 3 days)*

***Cough and Cold:** Robitussin DM, Delsym, Coricidin HBP Cough and Cold (if high blood pressure), Mucinex (chest congestion) Tylenol Cold, Robitussin cough drops, Cepacol throat lozenges (sore throat)*

***Dental Care**: Xylocaine (local anesthesia) is allowed*


***If these medication do not relieve your symptoms or if you develop a fever greater than 100.4° F, notify your physician.***