Dear Expectant Parents,

Congratulations and Welcome to Carteret Ob-Gyn Associates. Whether this is your first pregnancy with our office or you have been with us before, thank you for choosing Carteret Ob-Gyn Associates to care for you during your pregnancy and delivery! The following letter will tell you everything you need to know and what to expect as you begin your care with us.

Having a baby is such an exciting time and you are probably anxious to start prenatal care. Before we can schedule your first appointment, you must complete the attached paperwork and return it to our office. You may fax the paperwork directly to our OB Coordinator at 252-240-0392. You may email the paperwork directly to our Ob Coordinator at ob@carteretobgyn.com, or you may drop the paperwork off with a receptionist at our Morehead City or Swansboro location. This paperwork will be reviewed by our OB Team and then our OB Coordinator will contact you to schedule your first appointment. We cannot schedule your first appointment without this information. Are you attempting to transfer from another office? We still need the attached paperwork and you must also provide us with complete copies of your current OB records before scheduling any appointments!

Your first appointment will be with our OB Nurse. You may bring 1 adult with you to this appointment however, this is the only appointment we do not allow children. At this appointment the nurse will review your health history, family history, and previous pregnancies. She will give you information regarding the pregnancy and what to expect throughout your care. Please be prepared to discuss any questions or concerns you may have with the nurse. You will also have prenatal bloodwork drawn at this appointment and meet with our OB Coordinator to discuss your insurance coverage.

**EFFECTIVE JUNE 1st 2018**

ALL PATIENTS WITHOUT 100% MATERNITY COVERAGE WILL BE REQUIRED TO PAY A $300 DEPOSIT AT THEIR FIRST APPOINTMENT.

PATIENTS WITH NO ACTIVE INSURANCE OR MATERNITY COVERAGE WILL BE REQUIRED TO PAY $600 DEPOSIT AT THEIR FIRST APPOINTMENT.

Your second appointment will be with one of our OB Providers. At this appointment you will have your first ultrasound, a physical exam, and review your bloodwork results. If for any reason you have already had an ultrasound with our office or another facility you may not have another one at this appointment. We begin listening for fetal heart tones at or around 12 weeks.

If you have any questions in regards to establishing your prenatal care, please contact our OB Coordinator at 252-247-1604.

Thank you for choosing Carteret ObGyn Associates for your OB Care!

Sincerely,
The Obstetrical Doctors of Carteret ObGyn Associates

Sheli Garrett-Albaugh, DO, FACOG
Megan Lambeth, DO
Nicole M. D’Andrea, MD, MPH, FACOG
Olivia J. McCallum, MD, FACOG
Theresa M. Johnson, MD, FACOG
Thomas T. Vradelis, MD, FACOG
Date ___________________  MR# ___________________

Patient Name ___________________________________________  DOB ____/____/_____ 

Patient’s Address ____________________________________________

Patient’s Home Phone # ___________________  cell # ___________________  SS # - - - -

Patient’s Insurance Company ____________________________________________

<table>
<thead>
<tr>
<th>PERSONAL HISTORY</th>
<th>Current Height</th>
<th>Current Weight</th>
<th>Current BMI</th>
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<tbody>
<tr>
<td>Do you have or have ever had:</td>
<td>YES</td>
<td>NO</td>
<td>EXPLAIN</td>
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<td>Anemia (low blood count)</td>
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<td>Arthritis (or autoimmune disease)</td>
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<td>Blood clotting disorder/DVT</td>
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<td>Bowel Disorders</td>
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<td>Breast Disease</td>
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<td>Cancer</td>
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<td>Diabetes</td>
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<td>Heart Disease</td>
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<td>Hypertension (high blood pressure)</td>
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<td>Hepatitis/liver disease</td>
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<td>• Other psychiatric illness</td>
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<td>Respiratory Disease or Asthma</td>
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<td>Seizure Disorder</td>
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<td>Thyroid Disease</td>
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Date of last menstrual period______________/Unknown  Is date definite NO/YES

Have you had a recent ER visit NO/YES  If YES, where _________________________________

WHEN and WHERE was your pregnancy confirmed _________________________________

List current medications _______________________________________________________

Do you consent to ultrasounds if medically necessary? _____ yes _____ no

HOW MANY TIMES HAVE YOU:
Been pregnant? _______  Had full-term deliveries? _______  Had preterm deliveries? _______  Had C-sections? _______  
Had miscarriages?_______  Had abortions?_______  Had tubal pregnancy?_______  Had twins?_______

*******************************************************************************Below for Office Use Only*******************************************************************************
**PREGNANCY HISTORY**

<table>
<thead>
<tr>
<th>Date of Delivery</th>
<th>Weeks</th>
<th>Pregnancy Outcome (cesarean, vaginal, miscarriage, abortion)</th>
<th>Gender</th>
<th>Weight</th>
<th>Delivery Location</th>
<th>Comments</th>
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**MENSTRUAL HISTORY**

Was last menstrual period a normal amount/duration  NO/YES
Were you on any type of birth control at conception  NO/YES  If yes, what kind__________________________
Pediatrician:________________________________________________________________________________________________________
Father of Baby Name:______________________________________________________________________________________________

**GENETIC SCREENING/TERATOLOGY**

Will you (the patient) be age 35 years or older at estimated time of delivery  NO/YES
Have you had more than 2 miscarriages or pregnancy losses  NO/YES
If yes, explain____________________________________________________________________________________________________
Have you had a stillbirth/fetal demise  NO/YES
If yes, explain______________________________________________________________________________________________

Please answer “Yes” if you (the patient), your partner, or anyone in either family has any of the following:

Neural tube defects (spina bifida, anencephaly)  NO/YES, explain who________________
Thalassemia  NO/YES, explain who________________
Down Syndrome  NO/YES, explain who________________
Tay Sachs  NO/YES, explain who________________
Canavan Disease  NO/YES, explain who________________
Sickle cell disease or trait  NO/YES, explain who________________
Familial dysautonomia  NO/YES, explain who________________
Hemophilia or other bleeding or clotting disorders  NO/YES, explain who________________
Muscular dystrophy  NO/YES, explain who________________
Cystic fibrosis  NO/YES, explain who________________
Huntington’s chorea  NO/YES, explain who________________
Mental retardation NO/YES, explain who____________________
If yes, was this person tested for Fragile X NO/YES
Autism NO/YES, explain who____________________
Other inherited genetic or chromosomal disorders NO/YES, explain who____________________

**ANCESTRY**
Circle if any of your patient’s family is of any of the following descents.
French Canadian, Ashkenazi Jewish, Cajun, Mediterranean, Greek, Italian, Asian

**INFECTION HISTORY**
Have you had a rash or viral illness since your last menstrual period NO/YES
Do you live with someone with TB or exposed to TB NO/YES
Do you or your partner have a history of genital herpes NO/YES
Do you or your partner have a history of Hepatitis B or C NO/YES
Do you have a history of any STDs (sexually transmitted diseases) NO/YES
This includes: Gonorrhea, Chlamydia, HIV, Syphilis

**ALLERGIES**
Are you allergic to any medications ____________________________
___________________________
___________________________
Do you have any common allergens (ex. Dust, grass, mold, etc.)
___________________________
___________________________

**MEDICATION**
REACTION

**PAST GYNECOLOGICAL HISTORY**
Do you have a history of any of the following:
Abnormal Pap smear NO/YES Date__________________________
Have you had a LEEP or conization procedure NO/YES Date____
History of HPV NO/YES Date______________________________
Infertility NO/YES Explain______________________________
Uterine abnormality (such as Bicornuate, arcuate) NO/YES Explain______________________________
DES (Diethylstilbuterol) Exposure NO/YES

**FAMILY HISTORY**
List any family history for a first degree relative (Father, Mother, Brother, Sister, Son, Daughter)
Diabetes:________________________________________________________________________
High Blood Pressure____________________________________________________________________
Heart Disease________________________________________________________________________
Breast Cancer________________________________________________________________________
Uterine Cancer________________________________________________________________________
Ovarian Cancer________________________________________________________________________
Colon Cancer________________________________________________________________________

OBIntakeQuestionnaire/OBForms/Dec2017
SOCIAL HISTORY
Do you or have you ever:
Smoked       NO/YES

Amount per day before pregnancy______________________
Amount per day during pregnancy______________________
How many years?_____________________________________
When did you quit?___________________________________

Amount per day before pregnancy______________________
Amount per day during pregnancy______________________
How many years?_____________________________________

Amount per day before pregnancy______________________
Amount per day during pregnancy______________________

Drink alcohol       NO/YES

Use caffeine       NO/YES

If yes, how much per day______________________________

Have you ever used drugs       NO/YES
If yes, please list what drugs and when last used____________________________________________________

Do you feel safe at home       NO/YES

Do you have a history of sexual abuse/rape       NO/YES

Any history of Domestic Violence       NO/YES

Will you accept blood transfusion in case of emergency?       NO/YES

History of blood transfusion       NO/YES
If yes, list date and reason of transfusion____________________________________________________

Do you plan to breast or bottle feed? ______________________________________________________

PAST SURGICAL HISTORY
List any surgeries
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Do you have a history of anesthesia complications?       NO/YES
If yes, explain___________________________________________________________________________
Risk Factors for Lead Exposure in Pregnant and Lactating Women

Check all that apply:

☐ Recent immigration (within 1 year)
☐ Living near a point source of lead – lead mines, smelters, or battery recycling plants (even if the establishment is closed)
☐ Working with lead or living with someone who does – (eg. Lead production, battery manufacturing, paint manufacturing, ship building, ammunition production, or plastic manufacturing)
☐ Using lead-glazed ceramic pottery
☐ Eating non-food substances (pica)
☐ Using alternative or complementary substances, herbs, or therapies
☐ Using imported cosmetics or certain food products
☐ Engaging in certain high-risk hobbies or recreational activities or having family members who do – (eg. stained glass production or pottery making)
☐ Renovating or remodeling older homes without lead hazard controls in place
☐ Consumption of lead-contaminated drinking water
☐ Having a history of previous lead exposure or evidence of elevated body burden of lead
☐ Living with someone identified with an elevated lead level
☐ Fishing industry that uses lead
☐ None

Signature___________________________________________  Date Completed_________________________