CARTERET OBGYN ASSOCIATES
3511 John Platt Drive – Morehead City, NC 28557 – (252) 247-4297
666 West Corbett Avenue – Swansboro, NC 28584 – (910) 235-8612
Fax (252) 247-7383 – Email carteretobgyn@embarqmail.com

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 — Nicole M. D'Andrea, MD, MPH, FACOG — Theresa M. Johnson, MD, FACOG
Megan Lambeth, DO — Olivia J. McCallum, MD, FACOG — Thomas T. Vradelis, MD, FACOG

Carteret OB-GYN Associates
OB Intake Questionnaire

Date ____________________ MR# ____________________

Patient Name ____ DOB ____/____/_____

Patient's Address ____

Patient's Home Phone # _______________________ cell # _____________________ SS # _____-_____-______

Patient's Insurance Company ____

PERSONAL HISTORY Current Height ___________ Current Weight ___________ Current BMI____________

Do you have or have ever had:	YES	NO	EXPLAIN
Anemia (low blood count)			
Arthritis (or autoimmune disease)			
Blood clotting disorder/DVT			
Bowel Disorders			
Breast Disease			
Cancer			
Diabetes			
Heart Disease			
Hypertension (high blood pressure)			
Hepatitis/liver disease			
Kidney Disease			
Psychiatric Disorders	_____	_____	__________________________
• Bipolar disorder	_____	_____	__________________________
• Depression	_____	_____	__________________________
• Other psychiatric illness	_____	_____	__________________________
Respiratory Disease or Asthma			
Seizure Disorder			
Thyroid Disease			

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 ********************

Accept? ___ Yes ___ No Doctor's Initials ________ Comments:	OB Interview ___________________________ OB Physical ___________________________

PREGNANCY HISTORY

Date of Delivery	Weeks	Pregnancy Outcome (cesarean, vaginal, miscarriage, abortion)	Gender	Weight	Delivery Location	Comments

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

	MEDICATION	REACTION
Are you allergic to any medications	________________________________	__________________
	________________________________	__________________
	________________________________	__________________
Do you have any common allergens	________________________________	__________________
(ex. Dust, grass, mold, etc.)	________________________________	__________________
	________________________________	__________________

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____

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?___________________________________

Drink alcohol NO/YES
Amount per day **before** pregnancy______________________
Amount per day **during** pregnancy______________________
How many years?_____________________________________

Use caffeine NO/YES
If yes, how much per day______________________________
Amount per day **before** pregnancy______________________
Amount per day **during** pregnancy______________________

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

____ When_________________________________

____ When_________________________________

____ When_________________________________

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__________________________

Reviewed by ______________________________________ Date___________________________________