VOLUSIA OBSTETRICS AND GYNECOLOGY

Name _____ Age _____ Date of Birth _____

Mailing Address _____

City _____ St _____ Zip_____

Home Phone _____ Driver's Lic#_____ SS# _____

Work Phone _____ Ext _____ Cell Phone _____ Race _____

Primary Physician _____ Referred by _____

Spouse's Name _____ Spouse's Date of Birth _____

Phone # best to reach you _____ Able to leave a detailed message at this # Y / N

Email _____

Pharmacy(Name/Intersection/Town)_____

Emergency Contact _____ Relation _____Phone _____

PATIENT'S EMPLOYMENT:

Employer _____

Address _____ City _____ St _____ Zip_____

INSURANCE INFORMATION:

Insurance Company _____ Policy Holder_____

Policy Holder SS # _____ Date of Birth _____

ID or Policy # _____ Group # _____

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MUST BE SIGNED:

RELEASE OF INFORMATION, BENEFIT ASSIGMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I hereby authorize Volusia OB/GYN to release information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photo copy of my signature to be used to process my insurance/Medicare claim for period of LIFETIME. I claim any insurance benefits due to me for services rendered by Volusia OB/GYN and authorize and direct my carrier to issue payment check (s) directly to Volusia OB/GYN regardless of insurance benefits, if any. I understand that I am fully financially responsible for all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose of pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by a carrier.

Should I be a Medicare patient, I have been informed that Medicare covers routine exams once every two years. I understand that should my insurance company deny my claim for this reason, I will be responsible for the cost of today's visit. Visits for annual exams and pap smears will be coded as such. We cannot change diagnosis codes after a visit, nor can we alter rates.

I have also been informed that should I require services in addition to my routine exam, there may be an office visit charge as well as the fee for the exam. Please also be aware it is the patient's responsibility to know which lab is participating with your insurance. After consent is obtained, if orders are sent to incorrect lab the bill will be that patients responsibility.

Signed_____ Dated_____

MENSTRUAL History: Age periods began _____ First day of last period _____/_____/_____

Periods every _____ days. Was this a normal period? Y / N

If no, explain _____

_____

OBSTETRICAL History: Number of total pregnancies _____ Live Births _____

Miscarriages _____ Abortions _____ Premature Births _____

Age of children _____ Comments: _____

_____

CONTRACEPTIVE History: Current Method _____

List all methods (used formerly & length of use) _____

_____

ALLERGY History: Please list all medication allergies: _____

_____

MEDICAL History:

		YEAR			YEAR			YEAR
Anemia	Y/N	_____	Seizures	Y/N	_____	Stroke	Y/N	_____
Migraine Headache	Y/N	_____	Diabetes	Y/N	_____	Arthritis	Y/N	_____
High Blood Pressure	Y/N	_____	Heart Failure	Y/N	_____	Alcohol	Y/N	_____
Heart Attack	Y/N	_____	Rheumatic Fever	Y/N	_____	Asthma	Y/N	_____
High Cholesterol	Y/N	_____	Stomach Ulcers	Y/N	_____	Colitis/IB	Y/N	_____
Lung Disease	Y/N	_____	Liver Disease	Y/N	_____	Cancer	Y/N	_____
Hepatitis A,B or C	Y/N	_____	Urine Incontinence	Y/N	_____	Phlebitis	Y/N	_____
Bladder Infection	Y/N	_____	Thyroid Disease	Y/N	_____	Lupus	Y/N	_____
Kidney Disease	Y/N	_____	Sickle Cell	Y/N	_____	Anxiety	Y/N	_____
Blood Transfusions	Y/N	_____	Stroke	Y/N	_____	Depression	Y/N	_____
						Other mental conditions	Y/N	_____

Do you smoke? Y / N If yes, how many packs a day? _____

GYNECOLOGICAL History:

		YEAR			YEAR			YEAR
DES Exposure	Y/N	_____	Abnormal Pap	Y/N	_____	Chlamydia	Y/N	_____
Recurrent Vaginitis	Y/N	_____	Pelvic Infections (PID)	Y/N	_____	Gonorrhea	Y/N	_____
Endometriosis	Y/N	_____	Chronic Pelvic Pain	Y/N	_____	PMS	Y/N	_____
Pain w/Intercourse	Y/N	_____	Fibroid Tumors	Y/N	_____	Herpes	Y/N	_____
Condyloma (warts)	Y/N	_____	Ovarian Cysts	Y/N	_____	AIDS/HIV	Y/N	_____
Urinary Incontinence	Y/N	_____	Pelvic Pressure	Y/N	_____	Infertility	Y/N	_____
Recurrent Miscarriage	Y/N	_____	Cervical Cancer	Y/N	_____	Breast Pain	Y/N	_____

SURGICAL History: Please list all surgical procedures and their year _____

_____

_____

FAMILY History: Any family history of heart disease, cancer, mental problems, diabetes, breast or gynecological problems? If yes, List who and what problems: _____

_____

MEDICATION History: Please list ALL medications with strength and dosage: _____

_____

VOLUSIA OBSTETRICS AND GYNECOLOGY
500 HEALTH BLVD ~ DAYTONA BEACH, FL 32114
Phone 386-252-5858 Fax 386-252-4477

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CONSENT FOR TREATMENT

With any medical treatment, there is some risk involved. I hereby give consent to Volusia Obstetrics and Gynecology to provide and perform any medically indicated examination and treatment including but not limited to a pelvic exam for the below mentioned patient.

The consent will remain active until I withdraw my consent in writing.

_____ _____
Patient/Responsible Party *Date*

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CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. _____ or his/her staff to examine and/or treat as described above.

_____
Relationship

_____
Full name of child

_____ _____
Responsible Party *Date*

_____
Witness

Acknowledgement of Receipt
Notice of Patient Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient / Legal Representative Signature	Print Patient / Legal Representative Name	Date	Employee Initial

Acknowledgement NOT obtained because:

_____ Patient or Legal Representative declined Notice of Patient Privacy Practices.

_____ Other (briefly describe) _____

_____

_____
Employee Signature

Please list anyone with who we are able to discuss your care, finances, etc.

Name	Relationship
Name	Relationship
Name	Relationship

CONTRACEPTION:

When are you planning on having another child? (please check one)

___ Within the next year ___ Within the next 5 years

___ Within the next 10 years ___ I am done having children

MENSTRUAL PERIOD:

1. Do you ever feel as though your periods impact the quality of your life? ___ Y ___ N
2. Do you ever experience irregular or inconsistent bleeding patterns? ___ Y ___ N
3. Age period started _____, how often-every _____ days, length of period _____.

URINARY HEALTH:

1. Do you ever leak urine when you cough, laugh or sneeze? ___ Y ___ N
2. Do you ever feel as though you have to urinate urgently? ___ Y ___ N
3. Do you feel like you have to urinate too frequently? ___ Y ___ N
4. Do you ever experience painful urination? ___ Y ___ N

Patient:_____Age:_____Date:_____

REVIEW OF SYSTEMS

Do you currently have any issues with the following systems? Circle Y for yes or N for no

General Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other		

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/Sluggish	Y	N
Other		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Hrtburn	Y	N
Other		

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent	Y	N
Other		

Muscoloskeletal

Joint Pain	Y	N
Knee Pain	Y	N
Back Pain	Y	N
Other		

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other		

Genitourinary

Urinary Incontinence	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other		

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other		

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting probs	Y	N
Other		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other		

Psychiatric

Are you happy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Is there anyone in your home hitting or hurting you?	Y	N

Last pap smear/was it normal?_____ Any allergies?_____

Last colonoscopy/was it normal?_____ First day of last period?_____

Last mammo/was it normal?_____ Year of menopause_____or year of hyst_____

Last Bone Density Scan/was it normal?_____ Last lab work?_____

Primary care Doctor?_____ Dermatologist? _____

Any new surgeries?_____ Any new hospitalizations?_____

Have you completed the HPV vaccine series?_____

Alcohol/how much/often?_____ Caffeine/per day?_____

Smoking/per day?_____ Do you exercise?_____Contraceptive Method:_____

Family medical history:_____

Please list **ALL** medications, including vitamins, with strengths & frequency:_____

_____

Are you currently sexually active? _____ if so, with men, women or both?_____

Have you had a flu vaccination this year?_____ if not are you interested in having one?_____

VOLUSIA OBSTETRICS & GYNECOLOGY
PRENATAL INFORMATION FORM

Please fill this form out completely before your appointment.

Name _____

Previous Pregnancy information (including miscarriage and abortion)

Delivery Date	Length of pregnancy	Length of labor	Complications	Birth weight	Male or female	Epidural given?	Vaginal or C-section	Place of delivery

Occupation: _____

Highest level of education completed: _____

First day of your last menstrual cycle _____

In this pregnancy, have you had

- bleeding ☐
- odor ☐
- discharge ☐
- abdominal pain ☐
- bladder complaints ☐
- nausea/vomiting ☐

We only deliver at FL Memorial Hospital _____Initials

Our Birth Plan, designed for the safety of you and your baby:

At Volusia OB/GYN, we are avid and firm believers in having an educated, informed, and engaged patient population. We are also, passionately ardent believers in the importance of evidence based medicine. For those reasons, we have outlined our birth plan for you, our patient. This birth plan is designed with over 50 years of combined experience caring for mothers and their babies. We ask that you review it carefully and ask questions about it (preferably before 28 weeks). By reviewing this early in your pregnancy, you can ensure that we are the right practice for you.

1) **IV ACCESS:** IV access is critical. Obstetrics is a specialty where there is potential for excess bleeding. Even when things appear to be going well, significant blood loss can occur without much warning. Obtaining IV access once a hemorrhage begins can be difficult. Having early IV access keeps the risk of bad outcomes associated with bleeding to a minimum. IV fluid is also one of the tools we utilize to help babies that go into distress.

2) **FETAL MONITORING DURING LABOR:** We are aware of, and understand, our college's (ACOG, The American College of Obstetrics and Gynecology) position on intermittent auscultation and monitoring in low risk labor patients. This however, requires a 1:1 labor nurse to patient ratio, which we cannot guarantee at our labor unit. Thus, we will monitor mothers in labor with continuous fetal monitoring, as we strongly believe this is safest for mom and baby. Our labor unit has wireless monitors available. These provide greater freedom of movement and are water-resistant in case our moms wish to shower.

3) **ELECTIVE INDUCTIONS:** We discourage elective inductions of labor. We believe there is no better labor than natural labor. Induction of labor automatically increases your risk of having a cesarean section. Having said that, we will consider an induction at 39 weeks, if you are a minimum of 3cm dilated.

4) **GOING PAST YOUR DUE DATE:** We do not recommend that pregnancies progress past 41 weeks, as we believe the placenta function deteriorates once that gestational age is reached. This could increase risks to the baby. We will consider extending a low risk pregnancy past 41 weeks if conditions are optimal, potential risks are understood, and mom agrees to additional office fetal monitoring. Under no circumstances will we support a decision to extend a pregnancy past 42 weeks.

5) **ELECTIVE CESAREAN SECTION:** We will discourage requests for elective primary (first baby) cesarean sections. A cesarean section, although generally safe, incurs higher risks than a vaginal delivery.

6) **THE PROCESS OF INDUCTIONS:** If an induction of labor is necessary, there are different methods to accomplish this. Sometimes it is as simple as rupturing your membranes ("breaking your bag of water"), but often medications are required. The type of medication needed will depend on how favorable (dilated) your cervix is at the time of induction. Pitocin (Oxytocin) is often used to start or augment labor. We consider it a very safe drug with minimal potential adverse side effects. As noted in #3 above, we do not advocate elective inductions. Thus, if a medical induction is required, we hope you trust our judgment in which medication or medications to utilize to safely and effectively get you in labor and hopefully achieve a vaginal delivery. We are not intervention-heavy doctors. Our cesarean section rate shows that, by being significantly below the national average. We do not practice "convenience obstetrics". We practice evidence based obstetrics.

7) **THE USE OF FORCEPS OR VACUUM FOR VAGINAL DELIVERY:** We will on occasion recommend an operative vaginal delivery (vacuum or forceps). The only instances this is offered is if we believe we can safely and quickly deliver your baby in case of an emergency or

if you become too exhausted to push your baby out. This would avoid a cesarean section and get the baby out quicker than an emergent cesarean can. All the physicians at VOG have had extensive training in operative deliveries and will of course discuss it with you if we think one is necessary.

8) **EPISIOTOMY:** We do not perform routine episiotomies.

9) **TOLAC / VBAC:** We do selectively offer trials of labor in patients with 1 prior low transverse cesarean section (TOLAC) in hopes of achieving a vaginal delivery (VBAC). Not every patient is a good candidate for TOLAC. We will gladly review each case individually and review the benefits and risks involved. If we do not believe you are a good TOLAC candidate, we will recommend a repeat cesarean section. We are aware of ACOG's position on possible trial of labor after low vertical, classical and/or multiple previous cesarean sections. We believe these circumstances warrant delivery at a tertiary care center. Given that our labor unit is not, we will not support a trial of labor in these patients.

10) **PAIN MANAGEMENT DURING LABOR:** Your pain management will be your choice, not ours, not your family's, but yours. We will not agree to anyone but you making pain management decisions. We will not push any pain management modality, but will gladly educate you on options.

11) **DELAYED CORD CLAMPING:** We will attempt to delay cord clamping and cutting for 90-120 seconds, as recommended by the ACOG. If we, or the nursery/pediatric personnel, feel that the baby has to be attended to immediately, delayed cord clamping will not be our priority. During a cesarean section we will gladly perform a cord "milking" at your request. Delayed cord clamping during a section may cause additional blood loss to you, and we wish to avoid that.

12) **SKIN-TO-SKIN:** Skin to skin contact and breastfeeding will be supported, even during cesarean sections, as long as it is safe for mom and baby.

13) **MEDICATIONS/VACCINATIONS FOR BABY:** Medication concerns regarding your baby (vaccinations, antibiotics, vitamin K, etc.) are for you to discuss with your pediatric team. We will gladly offer advice but will not be a part of this decision making process.

14) **PLACENTAL PRESERVATION:** Although no current data support placental preservation for later consumption, we will gladly help you procure yours if you decide to keep it. You should be aware that the CDC specifically advises against the consumption of dried placenta capsules or any form of placental ingestion.

15) **VAGINAL SEEDING:** We will not perform "vaginal seeding" or any procedure to introduce vaginal organisms to your baby. This practice is currently being discouraged by ACOG.

16) **VISITORS DURING LABOR:** We generally do not limit visitors to your labor room. Having said that, if an emergency were to arise, we hope you understand we may need to remove visitors in order to make room for critical personnel. One person is generally allowed in the operating room during cesarean sections.

17) **EATING/DRINKING DURING LABOR:** We will generally allow small amounts of clear liquids during active labor. Your IV fluids will keep you well hydrated. Remember nausea is common during the advanced stages of labor and we want to avoid a full stomach. If a need for a cesarean section were to arise, a full stomach increases anesthesia risk.

18) **ASSISTANCE BY FAMILY MEMBERS:** We welcome assistance from family members as patient advocates and coaches. We appreciate your help with patient positioning and comfort measures. We will absolutely do our very best to have the designated family member cut the

umbilical cord. Please understand that sometimes this is not safe and trust us to make that decision for you and your baby. We occasionally receive requests from a family member to aid with the delivery of the infant. Babies are precious and delicate. Babies are slippery. We will deliver your baby.

19) **PHOTOGRAPHY, LIVE STREAMING AND VIDEO:** Photography is allowed in the delivery room as well as the operating room. The hospital has a strict no video, no live streaming policy during procedures.

We are available to answer any questions regarding our birth plan. If, after reviewing it, you feel our practice philosophy is not for you, we completely understand and wish you and your family the best.

Sincerely,

Your VOG Physicians

MEDICATIONS SAFE IN PREGNANCY

COLDS

Tylenol products
(cold, sinus, regular, extra strength, PM)
Benadryl, Claritin, Zyrtec
Robitussin DM
Cough Drops, throat lozenges, saline nasal drops

CONSTIPATION

Prunes, lots of fluids, cantaloupe, watermelon, strawberries
Natural fiber, raisin bran cereal
Stool softeners - dulcolax, colace, peri - colace
Metamucil, citrucel, fibercon, milk of magnesia
Extreme cases - Magnesium citrate, fleets enema

HEARTBURN/INDIGESTION

Tums, Rolaids - good calcium source
Maalox, Mylanta, Gaviscon
Pepsid, Zantac, Tagament - talk to your MD first

HEMORRHOIDS

Anusol HC, preparaion H, proctofoam, tucks

NAUSEA/VOMITING

Emetrol
Ginger Ale, Seabands

DIARRHEA

Kaopectate, Donnagel, Imodium

WHAT TO AVOID

Tetracycline, doxycyline, floxin antibiotics
General anesthesia
Ibuprofen products
Afrin or neosynephrine nasal sprays
Aleve