Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)	
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number
Insured's Address		City	State / Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name(as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

Notice of HIPPA practices acknowledgement: I have read and understand the Notice of Privacy Practices.
May we leave a detailed message on your voice mail: ___Yes ___ No (_____)_____

I herby authorize the Physicians of Gentle Gynecology & Obstetrics or Staff to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim. I also authorize the Physicians of Gentle gynecology & Obstetrics or Staff to obtain medical records from other facilities or Physicians for my continued medical care. This may include but is not limited to the following reports; Pap smear, pathology , pelvic sonograms, breast imaging, Obstetrical imaging & records and laboratory results that may include H.I.V. results & diagnosis. This release is valid for 1 year from signature.

_____ _____

Signature of Patient or Authorized Guardian | Date

Check-In by

PATIENT REGISTRATION

PHI (PROTECTED HEALTH INFORMATION) DISCLOSURE
We cannot discuss your protected health information (PHI) with anyone than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing.
1. _____ 2. _____

This authorization will remain in effect for one year unless otherwise specified. I understand this authorization extends to all or any part of my medical records. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained.

RELEASE OF MEDICAL RECORDS
If you wish to release your records to yourself, another physician or someone else, **you must sign a release**. We will process the request and most requests are handled within ten (10) business days. (fees may apply… see release of records form for more information.)

FINANCIAL POLICY
The doctors and staff at gentle gynecology & obstetrics would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

BY INITIALING AND SIGNING BELOW YOU CONFIRM THAT YOU HAVE READ THIS POLICY AND UNDERSTAND THAT:

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS
I hereby authorize gentle gynecology & obstetrics to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and i hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of gentle gynecology & obstetrics on behalf of myself and/or dependents, and i understand by making this request, I become fully financially responsible for any and all charges occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which i am entitled. I hereby authorize and direct my insurance carrier(s) including medicare, medicaid, private insurance and any other health/medical plan to issue payment directly to gentle gynecology & obstetrics, for medical service rendered to myself and/or my dependents regardless of my insurance benefits, if any.
I understand that not all services are covered benefits and i am responsible for any amount not paid, regardless of insurance policy.

Initials _____

We have elected not to carry medical malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to s-458.320 (5)(g). Florida law imposes penalties against non-insured Physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to florida law.

Initials _____

• It is your responsibility to inform our office of any address or telephone number changes. Your account is to be kept current---accordingly, all self pay or insurance co-payments, co-insurance and deductibles will be collected **at the time of services. Payable by: cash, check, Visa, Mastercard, and Discover.**

• If you do not have payment (s), your appointment may be rescheduled.

• A returned check will result in a $25 service charge **and** all future payment being required in the form of CASH or CREDIT CARD.

• There is a $10 charge for each request of completion for paperwork (ex: Disability, FMLA, etc…..)

• For our Gynecology patients there is a $15 charge for each blood draw. For Obstetrical patients a 1 time fee of $40 for routine tests required in pregnancy. Bio-Identical patients are not subject to these charges for tests related to Hormone Therapy.

Initials _____

• If unable to keep your appointment, please notify us ***24 hours*** in advance so that we may offer that time to another patient. A pattern of repetitive **"no show" or late cancellations may regretfully result in an assessment of a cancellation/no show fee of $25 for each incident.**

• If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **We are here to help you.**

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____

Signature (Patient's Parent/Guardian, if a Minor **Date**

Gentle Gynecology & Obstetrics

Michael F. Augustino, M.D., F.A.C.O.G.
Fabienne Achille, M.D., F.A.C.O.G.
Leonardo N. Catalano, M.D., F.A.C.O.G.

Consent for Voice and Text Messaging Communication

In an effort to relay **Normal results** faster to our patients we have implemented Electronic Medical Records. I understand that in order for Gentle Gynecology & Obstetrics to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Gentle Gynecology & Obstetrics.

I further understand that in order for Gentle Gynecology & Obstetrics to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Gentle Gynecology & Obstetrics.

I also understand that my healthcare information at Gentle Gynecology & Obstetrics is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages:
I give my written express consent to Gentle Gynecology & Obstetrics to leave detailed messages on my voicemail/answering machine about my **NORMAL** lab, ultrasound, breast imaging, prescription information, reminders or Pap smear results. I also give my written express consent that this information may be communicated to me via Text message.

I understand that "sensitive" information as noted below will be excluded.

- **No abnormal results** will be communicated via our automated system.
- **No HIV results** are disclosed by phone, mail, email or text. HIV results are only given in person to the patient as stipulated by H.I.P.P.A. Law.

Patient Name (Please Print)

Patient Signature

Date

Cell: (This number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time.

I understand that I must provide written notice to Gentle Gynecology & Obstetrics in order to revoke this consent.

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height:

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates(Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Check-In by

Name _____ Gender _____ Age _____

Date of Appointment: _____

OBGYN History

Have you ever had or do you currently have any of the following?

- ☐ Abnormal Vaginal Bleeding
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Breast Surgery
- ☐ Cervical Cancer
- ☐ Chlamydia
- ☐ Colposcopy
- ☐ Cryosurgery
- ☐ DES Exposure
- ☐ Extreme Menstrual Pain
- ☐ Fibroids
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Hot Flashes
- ☐ HPV
- ☐ Infertility
- ☐ Irregular Periods/Bleeding
- ☐ Nipple Discharge
- ☐ Ovarian Cysts
- ☐ Ovarian Cancer
- ☐ Painful Intercourse
- ☐ Pelvic Inflammatory Disease
- ☐ Uterine Cancer
- ☐ Urinary Incontinence
- ☐ Yeast Infections – Frequent

Pregnancy History

Please describe any pregnancies you have had.

# of Pregnancies _____ # of Full Term _____ # of Miscarriages _____ # of Abortions _____

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?

Are you currently pregnant?

☐ Yes ☐ No

Are you trying to become pregnant?

☐ Yes ☐ No

Do you need birth control or contraceptive advice?

☐ Yes ☐ No

What method of birth control do you use?

Menstrual History

When was the first day of your last period?

How often does your period occur?

How long does your period last?

Is your period regular?

☐ Yes ☐ No

What age were you when you had your first period?

What age were you at menopause?

Health Exams & Procedures

Please check and date all immunizations you have had.

	Month & Year	Results
☐ Blood Sugar-Fasting		
☐ Breast Self Exam		
☐ Cholesterol Test		
☐ Colonoscopy		
☐ CT/CAT Scan		
☐ Dexascan (Bone Density)		
☐ EKG		
☐ Echocardiogram		
☐ Fecal Occult Blood Test		
☐ Mammogram		
☐ MRI		
☐ Pap Smear		
☐ Physical Exam		
☐ Cardiac Stress Test		
☐ Ultrasound		

Check-In by

Name _____ Gender _____ Age _____

Date of Appointment: _____

Review of Systems

General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth – Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Weight Loss

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide –Thoughts/Attempts

Musculoskeletal
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

Other Symptoms

_____

_____

_____

_____

_____

Race

This information is needed for prenatal testing. Please feel free to ask you doctor any question you may have regarding information gathered.

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Check-In by _____

Patient Addressograph

DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

PRIMARY PROVIDER/GROUP _____

FINAL EDD _____

ADDRESS _____

BIRTH DATE AGE RACE MARITAL STATUS MONTH DAY YEAR S M W D SEP	ADDRESS
OCCUPATION EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)
LANGUAGE ETHNICITY	INSURANCE CARRIER/MEDICAID #
HUSBAND/DOMESTIC PARTNER PHONE	POLICY #
FATHER OF BABY PHONE	EMERGENCY CONTACT PHONE

TOTAL PREG	FULL TERM	PREMATURE	AB, INDUCED	AB, SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENSES MONTHLY ☐ YES ☐ NO FREQUENCY: Q _____ DAYS MENARCHE _____ (AGE ONSET)
☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION PRIOR MENSES _____ DATE ON BCP AT CONCEPT ☐ YES ☐ NO hCG + ____/____/____
☐ FINAL _____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES		
2. HYPERTENSION		
3. HEART DISEASE		
4. AUTOIMMUNE DISORDER		
5. KIDNEY DISEASE/UTI		
6. NEUROLOGIC/EPILEPSY		
7. PSYCHIATRIC		
8. DEPRESSION/POSTPARTUM DEPRESSION		
9. HEPATITIS/LIVER DISEASE		
10. VARICOSITIES/PHLEBITIS		
11. THYROID DYSFUNCTION		
12. TRAUMA/VIOLENCE		
13. HISTORY OF BLOOD TRANSFUS.		

	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE
14. TOBACCO			
15. ALCOHOL			
16. ILLICIT/RECREATIONAL DRUGS			

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
17. D (Rh) SENSITIZED		
18. PULMONARY (TB, ASTHMA)		
19. SEASONAL ALLERGIES		
20. DRUG/LATEX ALLERGIES/ REACTIONS		
21. BREAST		
22. GYN SURGERY		
23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)		
24. ANESTHETIC COMPLICATIONS		
25. HISTORY OF ABNORMAL PAP		
26. UTERINE ANOMALY/DES		
27. INFERTILITY		
28. ART TREATMENT		
29. RELEVANT FAMILY HISTORY		
30. OTHER		

COMMENTS _____

ACOG ANTEPARTUM RECORD (FORM A)

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. PATIENT'S AGE 35 YEARS OR OLDER AS OF ESTIMATED DATE OF DELIVERY			13. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80			14. MENTAL RETARDATION/AUTISM		
			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			15. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. CONGENITAL HEART DEFECT			16. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
5. DOWN SYNDROME			17. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6. TAY–SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)			18. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
7. CANAVAN DISEASE (ASHKENAZI JEWISH)			19. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)					
9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. HEMOPHILIA OR OTHER BLOOD DISORDERS			20. ANY OTHER		
11. MUSCULAR DYSTROPHY					
12. CYSTIC FIBROSIS					

COMMENTS/COUNSELING _____

_____

INFECTION HISTORY	YES	NO	
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HEPATITIS B, C YES ☐ NO ☐
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			5. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, HIV, SYPHILIS (CIRCLE ALL THAT APPLY)
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			6. OTHER (SEE COMMENTS)

COMMENTS _____

_____ **INTERVIEWER'S SIGNATURE** _____

INITIAL PHYSICAL EXAMINATION

DATE ____ / ____ / ____ WEIGHT _____ HEIGHT _____ BMI _____ BP_____

1. HEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS
2. FUNDI	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE
3. TEETH	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	_____ WEEKS		☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS	
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL	
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO	_____ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT	☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT	☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS (Number and explain abnormals) _____

_____

_____ **EXAM BY** _____

Gentle Gynecology & Obstetrics

Michael F. Augustino, M.D., F.A.C.O.G.
Fabienne Achille, M.D., F.A.C.O.G.
Leonardo N. Catalano, M.D., F.A.C.O.G.

I have been furnished information by Gentle Gynecology & Obstetrics, prepared by the Florida Birth-Related Neurological Injury Compensation Association, and have been advised that Dr. Michael F. Augustino, Dr. Fabienne Achille, & Dr. Leonardo N. Catalano are participating physicians in the program, where in certain limited compensation is available in the event certain neuro-logical injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association (NICA), 1435 Piedmont Drive East, Suite 101, Tallahassee, FL 32312. 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

In the event of an emergency or when doctors Augustino, Achille, & Catalano are on vacation, the physician will be the "On-Call" covering physician:
Dr. Emil Abdalla

DATED this _____ day of _____, 20_____.

_____
Signature

_____
Name of Patient **(Please Print)**

_____
Social Security

Attest:

_____
Witness

_____
Date
SEE SECTION 766.316, FLORIDA STATUES

Gentle Gynecology & Obstetrics

Michael F. Augustino, M.D., F.A.C.O.G.
Fabienne Achille, M.D., F.A.C.O.G.
Leonardo N. Catalano, M.D., F.A.C.O.G.

CONSENT TO HIV-1 ANTIBODY TESTING IN PREGNANCY

The purpose of the test, its potential uses, and the limitations and the meaning of the results have been explained to me. I understand that if the results indicate that my blood contains antibody to HIV, it means that I may *have* been infected with the HIV virus, which is believed to cause AIDS (Acquired Immune Deficiency Syndrome)

AT FIRST PRENATAL VISIT

☐ I authorize my health care providers to collect one or more blood specimens from me at the time if my' first prenatal visit in order to detect whether or not I have antibodies in my blood to HIV-1 (human immunodeficiency virus). This is the *virus* which has been associated with AIDS (Acquired Immune Deficiency Syndrome). I understand that my physician will report the test results to me in person and not by telephone or mail. At that time, I will have the opportunity to *receive* counseling about the meaning of the test results, the possible need for retesting, and other matters. Information regarding measures for the prevention of exposure to, and transmission of HIV has been made available to me.

CONSENT TO RELEASE

I understand that the test results will be confidential and only be disclosed to me in person at the offices of Gentle Gynecology& Obstetrics unless permitted or required by law. I hereby consent to the release of the test results to Gentle Gynecology& Obstetrics. I understand Gentle Gynecology & Obstetrics will comply strictly with the law regarding access to results by all staff.

☐ **REFUSAL OF HIV-1 ANTIBODY TESTING**

With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered with full knowledge of the consequences, I refuse to give my consent for HIV testing.

Patient Signature _____ **Date** _____

Witness Signature _____ **Name of Patient (Please Print)** _____

☐ **Authorization for Repeat HIV Testing in Third Trimester of Pregnancy**

I authorize my health care provider to repeat the testing for sexually transmitted diseases and HIV later in this pregnancy. This consent for repeat testing is limited to the course of my current pregnancy. I understand that my health care provider will discuss testing with me before the retest is performed and will provide me with the test results.

☐ **I Decline Repeat HIV Testing in Third Trimester of Pregnancy**

With the information presented *above* having been explained to me completely and clearly in the language I understand, all of my questions having been answered with full knowledge of the consequences, I decline repeat testing for sexually transmitted diseases and HIV later in this pregnancy.

Patient Signature _____ **Date** _____

Witness Signature _____ **Name of Patient (Please Print)** _____

Gentle Gynecology & Obstetrics

Michael F. Augustino, M.D., F.A.C.O.G.
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THIS TEST MAY NOT BE COVERED BY YOUR INSURANCE PLAN. BY SIGNING YOU AGREE TO PAY ALL COSTS INVOLED FOR TESTING. **PLEASE CALL YOUR INSURANCE CARRIER TO INQUIRE ON YOUR PRENATAL TESTING BENEFITS**

Patient Name:_____

CONSENT FOR INTEGRATED SCREEN

When a woman finds she is pregnant, she faces many choices. One important choice is whether to have a maternal serum screening test, such as Integrated Screen, to determine if she is at increased risk of having a baby with certain birth defects such as Down Syndrome trisomy 18 or open neural tube defects.

What is Integrated screen?
An Integrated *Screen* is a blood test which shows if you are at increased risk of having a baby with Down syndrome, trisomy 18, or an open neural tube defect. It requires a sample of your blood to drawn between 11 to 13.6 weeks of pregnancy along with an ultrasound measurement of the baby's neck (Nuchal Translucency) performed at the Pernatologist's office in the first trimester of pregnancy, a second blood sample is taken between 16 – 18 weeks of pregnancy(second trimester). *The Nuchal Translucency measurements, combined with your first & second trimester blood results will yield the final screening assessment.*

What is Down syndrome?
Down syndrome is caused by the presence of an extra chromosome #21 and results in both mental and physical abnormalities. Approximately 1 in 800 babies is born with Down syndrome, The risk of having a child with Down syndrome gradually increases with the age of the mother, but can occur at any maternal age.

What is trisomy 18?
Trisomy 18 is caused by the presence of an extra chromosome # 18 and results in serious mental retardation and physical deformities, including major heart defects. Approximately 1 in 6500 babies is born with trisomy 18. Only 1 out of 10 babies affected with trisomy 18 lives past the first year of life. As with Down syndrome, the risk of having an affected child gradually increases with the age of the mother.

What are open neural tube defects?
The neural tube, which forms very early in pregnancy, eventually develops into the baby's brain and spinal cord. If this tube does not close completely, an opening remains along part of the baby's spine or head. This can lead to paralysis and other physical and/or mental problems. Open neural tube defects occur in about 1 out of every 1,500 live births. The risk of having a child with an open neural tube defect does not increase with the age of the mother.

Your specific test result is affected by:
- Exactly how far along you are in your pregnancy when the ultrasound and blood samples are done.
- Your weight, ethnic background, and age.
- Whether you are an insulin-dependent diabetic or take certain types of medications.
- Whether a close relative has Down syndrome or an open neural tube defect.

□ I want the Integrated Screen with genetic counseling **□ NO testing at all**

_____ _____
Patient Signature **Date**

603 N. Flamingo Road, Suite 360A ● Pembroke Pines, FL 33028 ● Phone (954) 436-7667 ● Fax (954) 889-0025
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CONSENT FOR CYSTIC FIBROSIS CARRIER TESTING

Cystic fibrosis (CF) is an inherited disease that affects more than 25,000 American children and young adults. Symptoms of CF vary but include lung congestion, pneumonia, diarrhea and poor growth. Most people with CF have severe medical problems and some die at a young age. Others have so few symptoms they are unaware they have CF. CF does not affect intelligence. There is no cure for CF at this time. In the past many people with CF died at a very young age. Today, as a result of scientific advantages, many are living into their 20's and 30's.

IS THERE A CHANCE MY BABY COULD HAVE CYSTIC FIBROSIS?

You can have a child with CF even if there is no history in your family. Carrier frequency 1 in 30 average in U.S., varies by ethnicity. CF testing can help determine if you area carrier and at risk to have a child with CF. If both parents are carriers , there is a 1 in 4 (25%) chance, with each pregnancy, that they will have a child with CF. Carriers have one normal CF gene and one altered CF gene. People with CF have two altered CF genes. Most people have two normal copies of the CF gene.

Referral

We will arrange a consult with a Perinatologist for genetic counseling and additional testing if needed based on your results.

You should be certain you understand the following points:

The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause CF. The tests do not detect all carriers of these diseases. The laboratory needs accurate information about my family history for the most accurate interpretation of the test results. The decision to have the carrier testing is completely mine. No other tests will be preformed and reported on my sample unless authorized by my doctor, and any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory. The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.

□**I want** CF carrier testing.

□**I do not want** CF carrier testing.

_____ _____

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Patient Name:_____

CONSENT FOR CARRIER TESTING FRAGILE X SYNDROME

The most common inherited cause of mental retardation. Fragile X syndrome involves developmental delay, mental retardation, autism and hyperactivity. It primarily affects boys. Women who are carriers are at risk to have a child with mental retardation. Fragile X syndrome affects approximately 1 in 260 women and occurs in all ethnicities.

Inheritance

If a mother is a carrier, there is a 50% chance to have a child with Fragile X syndrome.

Consent

If I am a carrier, prenatal testing is available to find out whether or not the baby has inherited the abnormal Fragile X gene.

Referral

We will arrange a consult with a Perinatologist for genetic counseling and additional testing if needed based on your results.

You should be certain you understand the following points:

The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause Fragile X syndrome. The tests do not detect all carriers of these diseases. The laboratory needs accurate information about my family history for the most accurate interpretation of the test results. The decision to have the carrier testing is completely mine. No other tests will be preformed and reported on my sample unless authorized by my doctor, and any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory. The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.

□**I want *Fragile X*** testing.

□**I do not want *Fragile X*** testing.

_____ _____

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Patient Name:_____

CONSENT FOR CARRIER TESTING SPINAL MUSCULAR ATROPHY (SMA)

SPINAL MUSCULAR ATROPHY (SMA) is an inherited disease that affects 1 in 35 to 1 in 117 in the U.S., varies by ethnicity. SMA is the most common inherited cause of early childhood death. SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling their head or neck, and crawling or walking. The most common form of SMA affects infants in the first months of life and can cause death between 2-4 years of age. Less commonly the disease starts later and people can survive into adulthood. SMA does not affect intelligence. There is no cure or treatment.

Inheritance

If your test shows that you are a carrier of SMA, the next step is for your partner to have carrier testing preformed. Both parent s must be carriers for the baby to be at risk for SMA. If your partner has a negative test result and no family history of SMA the chance that your baby will have SMA is less than 1%. If both parent are carriers, there is a 1 in 4 (25%) chance to have a child with SMA.

Referral

We will arrange a consult with a Perinatologist for genetic counseling and additional testing if needed based on your results.

You should be certain you understand the following points:

The purpose of these tests is to determine whether I am a carrier of one of the common genetic abnormalities that cause SMA. The tests do not detect all carriers of these diseases. The laboratory needs accurate information about my family history for the most accurate interpretation of the test results. The decision to have the carrier testing is completely mine. No other tests will be preformed and reported on my sample unless authorized by my doctor, and any unused portion of my original sample will be destroyed within two months of receipt of the sample by the laboratory. The laboratory will disclose the results ONLY to my doctor, or to his/her agent, unless otherwise authorized by me or required by law.

□**I want *SMA*** testing.

□**I do not want *SMA*** testing.

_____ _____

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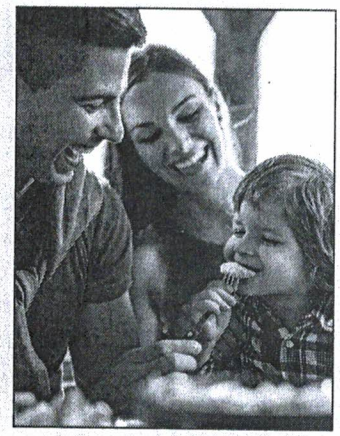
ADVICE ABOUT EATING FISH

For Women Who Are or Might Become Pregnant, Breastfeeding Mothers, and Young Children

Eating fish‡ when pregnant or breastfeeding can provide health benefits.

Fish and other protein-rich foods have nutrients that can help your child's growth and development. As part of a healthy eating pattern, eating fish may also offer heart health benefits and lower the risk of obesity.



Nutritional Value of Fish

The *2015-2020 Dietary Guidelines for Americans* recommends:

- At least 8 ounces of seafood (less for young children) per week based on a 2,000 calorie diet
- Women who are pregnant or breastfeeding to consume between 8 and 12 ounces of a variety of seafood per week, from choices that are lower in mercury.

Fish are part of a healthy eating pattern and provide:

- Protein
- Healthy omega-3 fats (called DHA and EPA)
- More vitamin B_{12} and vitamin D than any other type of food
- Iron which is important for infants, young children, and women who are pregnant or who could become pregnant
- Other minerals like selenium, zinc, and iodine.

Choose a variety of fish that are lower in mercury.

While it is important to limit mercury in the diets of women who are pregnant and breastfeeding and young children, many types of fish are both nutritious and lower in mercury.

This chart can help you choose which fish to eat, and how often to eat them, based on their mercury levels.

What is a serving? As a guide, use the palm of your hand.

For an adult
1 serving = 4 ounces

Eat 2 to 3 servings a week from the "Best Choices" list (**OR** 1 serving from the "Good Choices" list).

For children, a serving is 1 ounce at age 2 and increases with age to 4 ounces by age 11.

If you eat fish caught by family or friends, check for fish advisories. If there is no advisory, eat only one serving and no other fish that week.*

Best Choices
EAT 2 TO 3 SERVINGS A WEEK

- Anchovy
- Atlantic croaker
- Atlantic mackerel
- Black sea bass
- Butterfish
- Catfish
- Clam
- Cod
- Crab
- Crawfish
- Flounder
- Haddock
- Hake
- Herring
- Lobster, American and spiny
- Mullet
- Oyster
- Pacific chub mackerel
- Perch, freshwater and ocean
- Pickerel
- Plaice
- Pollock
- Salmon
- Sardine
- Scallop
- Shad
- Shrimp
- Skate
- Smelt
- Sole
- Squid
- Tilapia
- Trout, freshwater
- Tuna, canned light (includes skipjack)
- Whitefish
- Whiting

OR

Good Choices
EAT 1 SERVING A WEEK

- Bluefish
- Buffalofish
- Carp
- Chilean sea bass/ Patagonian toothfish
- Grouper
- Halibut
- Mahi mahi/ dolphinfish
- Monkfish
- Rockfish
- Sablefish
- Sheepshead
- Snapper
- Spanish mackerel
- Striped bass (ocean)
- Tilefish (Atlantic Ocean)
- Tuna, albacore/ white tuna, canned and fresh/frozen
- Tuna, yellowfin
- Weakfish/ seatrout
- White croaker/ Pacific croaker

Choices to Avoid
HIGHEST MERCURY LEVELS

- King mackerel
- Marlin
- Orange roughy
- Shark
- Swordfish
- Tilefish (Gulf of Mexico)
- Tuna, bigeye

* Some fish caught by family and friends, such as larger carp, catfish, trout and perch, are more likely to have fish advisories due to mercury or other contaminants. State advisories will tell you how often you can safely eat those fish.

www.FDA.gov/fishadvice
www.EPA.gov/fishadvice

EPA United States Environmental Protection Agency

FDA U.S. FOOD & DRUG ADMINISTRATION

This advice supports the recommendations of the *2015-2020 Dietary Guidelines for Americans*, developed for people 2 years and older, which reflects current science on nutrition to improve public health. The *Dietary Guidelines for Americans* focuses on dietary patterns and the effects of food and nutrient characteristics on health. For advice about feeding children under 2 years of age, you can consult the American Academy of Pediatrics.

‡ THIS ADVICE REFERS TO FISH AND SHELLFISH COLLECTIVELY AS "FISH" / ADVICE REVISED JULY 2019

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NO PM VERSIONS OF ANY MEDICATIONS ALLOWED IN PREGNANCY

Medication Name	1st Trimester	2nd Trimester	3rd Trimester
ANTACIDS / REFLUX / UPSET STOMACH			
Aciphex (rabeprazole) Rx	Yes	Yes	Yes
Gas-X	Yes	Yes	Yes
Nexium (lansoprazole) Rx	Yes	Yes	Yes
Pepcid (famotidine)	Yes	Yes	Yes
Pepto-Bismol (bismuth subsalicylate)	**No**	**No**	**No**
Plain Maalox, Mylanta, Tums, Rolaids	Yes	Yes	Yes
Prevacid (pantoprazole) Rx	Yes	Yes	Yes
Prilosec (omeprazole)	Yes	Yes	Yes
Protonix Rx (pantoprazole) Rx	Yes	Yes	Yes
Tagamet (cimetidine)	Yes	Yes	Yes
Zantac (ranitidine)	Yes	Yes	Yes
ANTIBIOTICS (all Rx)			
Amoxicillin, ampicillin Rx	Yes	Yes	Yes
Augmentin (amoxicillin +clavulanate) Rx	Yes	Yes	Yes
Bactrim (trimethoprin/ sulfamethoxazole) Rx	Yes	Yes	Yes
Cipro (ciproflaxcin), Levofloxacin (Levaquin) Rx	**No**	**No**	**No**
Clindamycin Rx	Yes	Yes	Yes
Doxycycline Rx	**No**	**No**	**No**
Erythromycin Rx	Yes	Yes	Yes
Keflex (cephalexin) Rx	Yes	Yes	Yes
Macrobid, Macrodantin (nitrofurantoin) Rx	Yes	Yes	**With Approval**
Metronidazole Rx	**No**	Yes	Yes
Tetracycline Rx	**No**	**No**	**No**
Zithromax (azithromycin) Rx	Yes	Yes	Yes
ANTI-DEPRESSANTS			
Discuss with provider/ NO Paxil (paroxetine)	**No**	**No**	**No**
ANTI-DIARRHEALS			
Imodium capsules (loperamide)	Yes	Yes	Yes
Kaopectate (bismuth subsalicylate)	**No**	**No**	**No**
ANTI-EMETICS			
Doxylamine (Unisome sleep tabs)	Yes	Yes	Yes
Kytril (granisetron) Rx	Yes	Yes	Yes
Phenegran (promethazine)Rx	Yes	Yes	Yes
Reglan (Metoclopramide) Rx	Yes	Yes	Yes
Zofran (ondansetron)Rx	Yes	Yes	Yes

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ANTIFUNGALS			
Diflucan (fluconazole) Rx	**No**	**No**	**No**
Gynazole 1 (butoconazole) Rx	**No**	Yes	Yes
Gyne-lotrimin 3 or 7-day (clotrimazole)	**No**	Yes	Yes
Monistat 1-day (miconzole,ticonazole)	**No**	Yes	Yes
Monistat 3 or 7-day (miconazole)	**No**	Yes	Yes
ANTIHISTAMINES / DECONGESTANTS / COUGH / COLD			
Allegra (fexofenadine) Rx	Yes	Yes	Yes
Afrin nasal spray (oxymetazoline)	**No**	**No**	**No**
Benadryl (diphenhydramine)	Yes	Yes	Yes
Chlor-trimeton (chlorpheniramine)	Yes	Yes	Yes
Clarinex, Alavert, Claritin (loratadine)	Yes	Yes	Yes
Cough Drops	Yes	Yes	Yes
Mucinex (guaifenesin)	Yes	Yes	Yes
Mucinex-D (guaifenesin+pseudoephedrine)	**No**	Yes	Yes
Phenylephrine	**No**	**No**	**No**
Robitussin Cough, Delsym (dextromethorphan)	Yes	Yes	Yes
Robitussin CF cough & cold (dextromethorphan + guaifenesin + phenylephrine)	**No**	**No**	**No**
Robitussin DM (dextromethorphan + guaifenesin)	Yes	Yes	Yes
Sudafed (pseudoephedrine)	**No**	Yes	Yes
Tylenol Cold & Flu	Yes	Yes	Yes
Zicam	Yes	Yes	Yes
Zyrtec (certirizine)	Yes	Yes	Yes
ANTIVIRALS			
Famvir (famcyclovir) Rx	Yes	Yes	Yes
Valtrex (valcyclovir) Rx	Yes	Yes	Yes
Zovirax (acyclovir) Rx	Yes	Yes	Yes
LAXATIVES / STOOL SOFTENERS			
Citrucel (methylecellulose powder)	Yes	Yes	Yes
Colace, pericolace (docusate sodium)	Yes	Yes	Yes
Dulcolax Tablets (bisacodyl)	Yes	Yes	Yes
Lactulose Rx	Yes	Yes	Yes
Milk of Magnesia	Yes	Yes	Yes
Miralax (PEG)	Yes	Yes	Yes
Senokat (senna)	Yes	Yes	Yes
PAIN / FEVER			
Aleve (naproxen sodium)	**No**	**No**	**No**
Aspirin	**No**	**No**	**No**
Motrin,Advil (ibuprofen)	**No**	**No**	**No**
Tylenol (acetaminophen)	Yes	Yes	Yes
Tylenol with codeine Rx		**With Doctor Approval**	
TOPICAL CREAMS / OINTMENTS			
Benadryl, hydrocortisone, caladryl	Yes	Yes	Yes
Retin A	**No**	**No**	**No**
Proacvtiv	Yes	Yes	YES

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