Name:_____

DOB:_____Date:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

New Obstetrical Patient Information

DEMOGRAPHICS

Date:	
Last Name:	
First Name:	
Middle Initial:	
Maiden Name:	
Date of Birth:	
Social Security #:	
Marital Status:	Sexual Preference: Heterosexual Lesbian Bisexual
Race:	
Ethnicity:	
Religion:	
Home Address:	
City, State, Zip:	
Cell Phone #:	
Email Address:	

EMPLOYMENT

Occupation:	
Employer:	
Work Phone #:	

FATHER OF THE PREGNANCY

Last Name:	
First Name:	
Date of Birth:	
Is he helpful:	Yes No

EMERGENCY CONTACT

Last Name:	
First Name:	
Address:	
City, State, Zip:	
Phone:	
Relationship:	

PREPREGNANCY DATA

When was the first day of your last period?	
What was the date of your positive pregnancy test?	
Pre pregnancy weight (pounds):	
Height:	
How many pregnancies have you delivered after 37 weeks?	
How many pregnancies have you delivered between 20 and 37 weeks?	
How many miscarriages, ectopic and molar pregnancies have you had?	
How many living children do you have?	

DATE:

New Obstetrical Patient Information

Patient Name: _____ Patient Date of Birth: _____

PRIOR PREGNANCIES

Delivery Date	Weeks	Time in Labor	Weight	Sex	Delivery Mode	Hospital	Preterm Labor	Complications

SURGICAL HISTORY

Year	Procedure

MEDICATIONS

Medicine	Dose	Frequency

Allergies to Medication:

SOCIAL HISTORY

Do you smoke?	Yes No
Do you drink alcohol?	Yes No
Do you use illegal drugs?	Yes No
Please indicate which substance you use:	
Please list any sexually transmitted disease you have had:	

PLANNING (circle those that apply)

How do you plan to feed your baby?	Breast Bottle Both
Do you desire to attempt to have a vaginal birth after cesarean section?	Yes No N/A
If your child is male, would you like him circumcised?	Yes No N/A
Which form(s) of anesthesia do you prefer?	None Local Narcotics Epidural Other:
Who is your pediatrician?	
Do you want to take childbirth classes?	Yes No Unsure

DATE:

New Obstetrical Patient Information

Patient Name: _____ Patient Date of Birth: _____

PRIOR MEDICAL PROBLEMS (circle those that apply)

Cardiac Disease	Angina	Myocardial Infarction	Pericarditis	Birth Defect of the Heart	Heart Failure	Cardio-myopathy	Mitral Prolapse
	Mitral Stenosis	Aortic Stenosis	Aortic Aneurysm	Mitral Regurg	High Blood Pressure	Atrial Fibrillation	Abnormal Rhythm
	Coronary Disease	Rheumatic Fever	Heart Block	Aortic Regurg	Pericardial Effusion		
Pulmonary Disease	Pneumonia	Pneumothorax	Asthma	Bronchiectasis	Sarcoidosis	Sleep Apnea	Emphysema
	Pulmonary Edema	DVT/Pulmonary Embolism	Pulmonary Hypertension	Cystic Fibrosis	Pulmonary Fibrosis	Bronchitis	Pleural Effusion
Renal Disease	Renal Artery Stenosis	Urinary Tract Infection	Kidney Infection	Ppolycystic Kidney	Renal Tubular Acidosis	Diabetes Insipidus	Glomerulo-nephritis
	Nephrotic Syndrome	Renal Failure	Bladder Cancer	Renal Cancer	Kidney Stones		
GI/Hepatic Disease	Malabsorption	Lactose Intolerance	Celiac Sprue	Reflux	Achalasia	Peptic Ulcer	Diverticulitis
	Gastritis	Ulcerative Colitis	Crohn's Disease	Colon Polyps	Pancreatitis	Hepatitis A	Hepatitis B
	Hepatitis C	Hepatitis Delta	Wilson's Disease	Hepatic Failure	Cirrhosis	Liver Carcinoma	Esophageal Cancer
	Pancreatic Cancer	Colon Cancer	Stomach Cancer	Gallstones			
Hematologic Disease	Iron Deficiency Anemia	Sickle Cell Anemia	Sickle Trait	Thalassernia	Neutropenia	Polycythemia Vera	Von Willebrand's Disease
	Lymphoma	Multiple Myeloma	Hemophilia	Thrombocytopenia	Leukemia	ITP	
Endocrine Disease	Obesity	Anorexia	Bulimia	Gout	High Cholesterol	Marfan's Syndrome	Hyperthyroidism
	Hypothyroidism	Goiter	Hemochromatosis	Grave's Disease	Thyroiditis	Addison's Disease	Cushing's Syndrome
	Rickets	Pheochromocytoma	Diabetes	Osteoporosis	Diabetes Mellitus		
Infectious Disease	Lyme Disease	Cat Scratch Disease	Shingles	HIV Infection	AIDS	Meningitis	Encephalitis
Neurologic Disease	Myasthenia Gravis	Muscular Dyst	Multiple Sclerosis	Myotonic Dyst	Cerebral Aneurysm	Spinal Cord Trauma	Head Injury
	Stroke	Epilepsy	Parkinson's Disease	Huntington's Chorea	Brain Tumor		
Psychiatric Disease	Schizophrenia	Depression	Bipolar Disorder	Panic Attacks			
Musculo-skeltal Disease	Osteoarthritis	Rheumatoid Arthritis	Bursitis	Scleroderma	Scoliosis	Lupus Erythematosis (SLE)	
Female Malignancy	Ovarian Cancer	Breast Cancer	Cervical Cancer				
Other							

DATE:

NAME: D.O.B.

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:_____	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Bay Area Women's Specialists

CORD BLOOD EDUCATION RELEASE FORM

I have acknowledged I have received information about the option of preserving my newborn baby's umbilical cord blood for my family. Should I wish to obtain additional information about umbilical cord blood preservation, I fully understand this responsibility will be solely and completely my own.

To obtain additional information about the benefits of umbilical cord blood preservation, ask your Bay Area Women's Specialists health care provider.

Patient Name (please print): _____

DOB: _____

Patient Signature: _____

Date: _____

CORD BLOOD BANKING OPTIONS

ABOUT CORD BLOOK BANKING

Cord blood banking is the once-in-a-lifetime opportunity for parents to save the stem cells found in the blood of their newborn's umbilical cord. The preservation of these stem cells, which are different from embryonic stem cells, allows families the benefit of having them available for existing or future medical treatments.

Cord blood banking is completely safe born both the mother and the newborn since cord blood is collected after the baby is born and after the umbilical cord has been clamped and cut.

CORD BLOOD BANKING OPTIONS

When deciding what is best for you and your family, it is important to know about all of your cord blood banking options.

__**Family Banking** allows you to store your newborn's cord blood stem cells specifically for your family making them available immediately should your family ever need them. This service is provided by cord blood banks which charge a fee for collection, processing, and storage in which you retain ownership of your newborn's stem cells. Research has shown that transplants with related cord blood stem cells have double the survival rates as compared with unrelated (publicly donated) cord blood stem cells.

__**Public Donation** allows your family to offer your baby's cord blood stem cells to the public network at no cost. Your donation may then be made available to any patient requiring a cord blood stem cell transplant. Your family does not retain ownership of the cord blood once it has been donated. As a result, there is no guarantee that it will be available should it be needed by a family member. A fee is charged for stem cells released by a public bank to a patient undergoing a medical treatment.

__**Designated Transplant Program** is a program that provides free collection, processing, and storage for qualifying families with a medical need. The cord blood is to be used by a family member suffering from a disease treatable with cord blood stem cells.

__**Medical Waste** means that the cord blood will be thrown out as waste. Once discarded, these cells cannot be retrieved for future use.

PLEASE KEEP PATIENT COPY

GC_SWHABAWS_Gemini Office

New Pregnancy Questionnaire

Dating Information

What was the date of your last menstrual period?

About

Height *

ft in

Pre-pregnancy Weight

lb

What is your occupation?

Is English your native language? No Yes

What is the name of your partner/spouse?

What is the phone number of your partner/spouse?

Is the father of the baby 40 or older?* No Yes

Sensitive

Has your current partner ever threatened you, or made you feel afraid?* No Yes

Have you ever been in an abusive relationship?* No Yes

Do you feel unsafe in the neighborhood where you live?* No Yes

Pregnancy History

Is this your first pregnancy?* No Yes

Have you ever had a C-Section? No Yes

Do you feel like you had a really stressful experience with any labor and delivery from any previous pregnancy? No Yes

Did you have a forceps assisted delivery in any previous pregnancy? No Yes

Did you ever have Vacuum Extraction delivery assistance on a previous pregnancy? No Yes

Did you deliver a larger than normal infant (baby greater 8lbs,13oz) on a previous pregnancy?	No	Yes
Have you ever lost a pregnancy after 14 weeks gestation?	No	Yes
Have you ever had your uterus rupture during pregnancy, labor, or delivery?	No	Yes
Have you ever had a placental abruption or placental separation?	No	Yes
Have any of your babies been infected with Group B Strep?	No	Yes
Have you ever had a baby who was too small or growth restricted?	No	Yes
Have you had Gestational Diabetes with a previous pregnancy?	No	Yes
Have you been diagnosed with high blood pressure/preeclampsia gestational hypertension or HELLP syndrome in your previous pregnancies?	No	Yes
Were you ever admitted with pre-term contractions or diagnosed with pre-term labor in a previous pregnancy?	No	Yes
Have you had a preterm delivery at less than 37 weeks?	No	Yes
Have you ever been diagnosed with a shortened cervix in a previous pregnancy?	No	Yes
During a previous delivery, did the baby's shoulder get stuck on the way out?	No	Yes
Have you ever had a hemorrhage after delivery with a previous pregnancy?	No	Yes
Have you had postpartum depression?	No	Yes
Were you ever re-admitted to the hospital after a delivery?	No	Yes
Did you have complications during a previous pregnancy or postpartum other than those listed above?	No	Yes

Endocrine History

Do you have an overactive thyroid, or Graves disease?	No	Yes
Do you have an underactive thyroid, or Hashimoto's thyroiditis?	No	Yes
Do you have insulin-dependent or juvenile (Type 1) diabetes?*	No	Yes

Do you have adult-onset (Type 2) diabetes?*	No	Yes
Do you have Polycystic Ovarian Syndrome (PCOS)	No	Yes

Cardiovascular History

Do you have high blood pressure?*	No	Yes
Do you have ITP, history of low platelet count, or a platelet disorder?*	No	Yes
Have you ever had a blood clot in the leg (DVT) or lung (Pulmonary Embolism) or a disorder that makes your blood clot more than usual?*	No	Yes
Do you have any cardiovascular problems (heart/heart valve disease, previous heart surgery, heart defects, aortic aneurysm, arrhythmia, rapid or irregular heartbeat, or postpartum heart failure)	No	Yes

Neurological History

Do you have any type of seizure disorder?	No	Yes
Have you ever been diagnosed with a stroke (CVA, TIA)?	No	Yes
Have you ever been diagnosed with migraines?	No	Yes

Psychiatric History

Do you have problems with anxiety?*	No	Yes
Have you had a problem with depression?*	No	Yes
Have you ever been diagnosed with PTSD?	No	Yes
Have you ever been diagnosed with OCD?	No	Yes
Have you been diagnosed with a bipolar (manic-depressive) disorder?	No	Yes
Do you have schizophrenia?	No	Yes
Have you ever attempted suicide?	No	Yes

Have you ever been diagnosed with ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)?		No	Yes

Respiratory History

Do you currently have asthma?*	In Past	No	Yes
Do you have any pulmonary disease or lung problems other than asthma?		No	Yes

Surgical History

Have you ever had any complications with anesthesia?	No	Yes
Have you ever had postoperative complications?	No	Yes
Have you had weight loss/bariatric surgery?*	No	Yes
Have you ever had a blood transfusion?*	No	Yes
Have you ever had back surgery?	No	Yes
Have you ever had abdominal surgery (including c-section)?*	No	Yes
Have you ever had cosmetic surgery (including breast augmentation, tummy tuck)?	No	Yes
Have you ever had transplant surgery	No	Yes

Gastroenterological History

Do you have Ulcerative Colitis?	No	Yes
Do you have Crohn's disease?	No	Yes
Do you have any history of gastrointestinal or digestive disorders other than the conditions noted above?	No	Yes

Urologic History

Have you ever had any urinary tract/urologic surgery?	No	Yes

Do you have any type of kidney/renal disease (including history of kidney stones or kidney infection)?*	No	Yes

General Medical History

Do you have antiphospholipid syndrome (APS) / thrombophilia / hypercoagulability?	No	Yes
Do you have lupus?	No	Yes
Do you have rheumatoid arthritis?	No	Yes
Do you have Sjogrens Syndrome?	No	Yes
Have you ever been diagnosed with or undergone treatment for a Blood Disorder?	No	Yes
Do you have a connective tissue disorder (Ehlers-Danlos or Marfan Syndrome)?	No	Yes
Have you ever been diagnosed with or undergone treatment for Cancer?	No	Yes

Gynecological History

Have you had 3 or more miscarriages?	No	Yes
Have you ever needed IVF or other treatment to get pregnant?	No	Yes
Have you ever had any surgery or procedures on your cervix?*	No	Yes
In a previous pregnancy, have you ever had your cervix sewn or taped closed due to a weak or incompetent cervix?*	No	Yes
Have you ever had a cold knife cone biopsy (conization) to remove tissue from your cervix?*	No	Yes
Have you ever had a LEEP (Loop Electrosurgical Excision Procedure) performed to remove abnormal cells from your cervix?*	No	Yes
Have you ever had cervix cryosurgery to freeze and destroy abnormal tissue in your cervix?*	No	Yes
Have you ever been diagnosed with a uterine anomaly such as a bicorunate, unicorunate, arcuate, or septate uterus?	No	Yes
Do you have (or have you had) uterine fibroids (myomas)?	No	Yes
Have you ever had an operation to remove a fibroid or myoma from your uterus?	No	Yes

Family History

Do you or your partner have an ethnic background of Cajun/French Canadian?	No	Yes
Do you or your partner have an ethnic background of Greek/Mediterranean/Italian?	No	Yes
Do you or your partner have an Ashkenazi/Eastern European Jewish background?	No	Yes
Has anyone in your or your partner's family had a baby with anencephaly?	No	Yes
Has anyone in either your or your partner's family had Canavan Disease?	No	Yes
Have you, your partner or either your or your partner's family had a chromosomal defect?	No	Yes
Has anyone in either your or your partner's family had familial dysautonomia (FD)?	No	Yes
Have you, your partner or either your or your partner's family had a heart defect?	No	Yes
Do you, your partner or either your or your partner's family have sickle cell anemia?	No	Yes
Has anyone in your or your partner's family had sickle cell trait (SCT)?	No	Yes
Has anyone in your or your partner's family had a child with Down syndrome?	No	Yes
Has anyone in your or your partner's family had hemophilia?	No	Yes
Has anyone in your or your partner's family had Muscular Dystrophy?	No	Yes
Do you, your partner or either your or your partner's family have cystic fibrosis?	No	Yes
Has anyone in your or your partner's family had Huntington's Chorea?	No	Yes
Has anyone in your or your partner's family had Fragile X?	No	Yes
Has anyone in your or your partner's family had spinal muscular atrophy (SMA)?	No	Yes
Have you, your partner or anyone in your or your partner's family had von Willebrand Disease?	No	Yes
Do you, your partner or anyone in either family have any birth defects?*	No	Yes
Does anyone in either your or your partner's family have an intellectual disability?	No	Yes

Do you, your partner or either your or your partner's family have any children with special needs?	No	Yes
Has anyone in the family had pre-eclampsia?	No	Yes
Do your or your partner's family have any close relatives (parent, child, sibling) with diabetes?	No	Yes

Infection History

Have you been exposed to tuberculosis?	No	Yes
Have you had a rash or viral illness since your last menstrual period?	No	Yes
Have you ever been diagnosed with MRSA?	No	Yes
Have you ever been diagnosed with Hepatitis B?	No	Yes
Have you ever been diagnosed with Hepatitis C?*	No	Yes
Are you HIV positive?	No	Yes
Have you ever been diagnosed with any sexually transmitted disease (STD) - (Gonorrhea, Chlamydia, Trichomonas, HIV, HPV, or Syphilis?	No	Yes
Have you ever had a genital herpes?	No	Yes
Does your partner have a history of genital herpes?	No	Yes
Have you ever had cold sores?	No	Yes

Vaccination History

Have you ever had chickenpox or been vaccinated against it?	No	Yes

Social History

Do you have any objections to blood transfusions?	No	Yes
Do you have a cat?	No	Yes
Do you have exposure to chemicals or radiation?	No	Yes

When was the last time you drank any alcohol?

Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

When was the last time you smoked, vaped, or used any tobacco/nicotine products?

Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

- Do you vape or use e-cigarettes?

  Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

- When was the last time you smoked a cigarette?

  Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

When was the last time you used marijuana, cocaine, meth, benzos, and/or opioids?

Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

- When was the last time you used any marijuana?

  Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

- When was the last time you used any cocaine?

  Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

- When was the last time you used any methamphetamines?

  Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

- When was the last time you used any benzos (such as Valium, Xanax, or Ativan)?

  Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

- When was the last time you used any opioids?

  Never | Years Ago | Weeks Ago | Not Since Pregnant | Current

Are you exposed to second-hand tobacco smoke?

No | Current

Options Counseling

Do you have questions about your options regarding this pregnancy?*

No | Yes