THE CENTER FOR WOMEN, INC.
4139 BOARDMAN-CANFIELD ROAD • CANFIELD, OH 44406
(330) 702-1281

PATIENT INFORMATION

TODAY'S DATE _____ PREFERRED PHARMACY _____ LOCATION _____

PATIENT'S NAME _____ DATE OF BIRTH _____ SS# _____

RACE ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ CAUCASION ☐ NATIVE HAWAIIAN
☐ AMERICAN INDIAN ☐ HISPANIC ☐ OTHER _____

ETHNICITY _____ PREFERRED LANGUAGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL ADDRESS _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SPOUSE'S NAME _____ DATE OF BIRTH _____ SS# _____
(OR RESPONSIBLE PARTY)

FAMILY DOCTOR _____ PREVIOUS OB/GYN SEEN _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DO YOU HAVE A LIVING WILL? _____ DO YOU HAVE A DURABLE POWER OF ATTORNEY? _____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER _____
☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ RETIRED

SPOUSE'S EMPLOYER _____
(OR RESPONSIBLE PARTY) ☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ RETIRED

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____

I hereby authorize Jennifer Baird, MD; Laura Musser, DO; Gaye Sympson, CNM; Cecelia Gallagan, WHNP; Julie Brennan, WHNP; and/or Stefanie Reed, WHNP to apply for benefits on my behalf for services rendered by them or by their order. I request payment from my insurance company to be made directly to The Center for Women, Inc.
I certify that the information reported with regard to my insurance coverage is correct. If my insurance company does not cover the cost of any services, I agree to be fully responsible for them. If I default on any payment, I will be responsible for collection costs including , but not limited to, collection agency fees, court costs, and reasonable attorney fees incurred to collect this debt. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.
I have read, fully understand and agree to the above.

SIGNATURE _____ DATE _____
(PATIENT, PARENT, OR GUARDIAN)

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HEALTH HISTORY

Please check box with a plus sign (+) if personal history or family history of diseases listed below. If answer is no - check each box with a minus sign (-). If yes - please explain, family member and type of problem.

	Personal History	Family History	If (+) Explain
Heart Disease			
Lung Disease			
Stomach / Bowel Problems			
Hormone Problems / Diabetes			
Anemia / Bleeding Problems			
Neurological Problems			
Psychiatric Problems (Depression, Anxiety, etc.)			
Cancer			
Stillbirth or Birth Defect			
Genetic Problems			
Multiple Births			
Drug Addiction / Smoking / Alcohol			
Have You Ever Had Chicken Pox?			
Sexually Transmitted Disease / HIV?			
Drug Allergies / Other Sensitivities?			
Surgery?			
Hospitalization			
Blood Transfusion			
Abnormal Paps / Cervical Surgeries			

OBSTETRICAL HISTORY

Please list ALL pregnancies including miscarriages and abortions.

Year	Length of Gestation	Length of Labor	Vag. or Ces. Delivery	Weight	Sex	Complications

Prenatal Genetics Screen

Name _____ Date _____

Date of Last Menstrual Period _____

(Please check the Yes or No box below)

1. Will you be 35 years or older when the baby is due? ☐ Yes ☐ No

2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders? (If yes, please indicate relationship to you)

			Relationship:
Downs Syndrome (mongolism)	☐ Yes	☐ No	
Chromosomal Abnormality	☐ Yes	☐ No	
Neural tube defect (spina bifida, anencephaly)	☐ Yes	☐ No	
Hemophilia	☐ Yes	☐ No	
Muscular Dystrophy	☐ Yes	☐ No	
Cystic Fibrosis	☐ Yes	☐ No	
Huntington's Chorea	☐ Yes	☐ No	

3. Did you or the baby's father have a birth defect? ☐ Yes ☐ No If yes, who has the defect and what is it?

4. In any previous pregnancies, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 3? ☐ Yes ☐ No

5. Do you or the baby's father have any close relatives with developmental disabilities? ☐ Yes ☐ No

6. Do you, the baby's father, or a close relative in either of your families, have a birth defect, familial disorder, or a chromosomal abnormality not listed above? ☐ Yes ☐ No

7. In any previous pregnancies, have your or the baby's father had a stillborn child, or three or more first trimester miscarriages? ☐ Yes ☐ No

8. Are you or the baby's father of Jewish ancestry? ☐ Yes ☐ No
   If yes, have either of you been tested for TaySachs disease? ☐ Yes ☐ No

9. Are you or the baby's father African-American? ☐ Yes ☐ No
   If yes, have either of you been tested for sickle cell trait? ☐ Yes ☐ No

10. Are you or the baby's father of Italian, Greek, or Mediterranean background? ☐ Yes ☐ No
    If yes, have either of you been tested for B-thalassemia? ☐ Yes ☐ No

11. Are you or the baby's father Philippine or Southwest Asian ancestry? ☐ Yes ☐ No
    If yes, have either of you been tested for a-thalassemia? ☐ Yes ☐ No

12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? ☐ Yes ☐ No
    If yes, give the name of the medication and the time taken during pregnancy:

Race: ☐ White / Caucasian ☐ Hispanic ☐ American Indian
☐ Black / African American ☐ Asian ☐ Other _____

Patient's Signature _____ Patient's Name (Printed/Typed) _____

Physician/Provider Signature _____ Date _____