Gwinnett OB/GYN Associates, P.C.
1700 Tree Lane Road • Suite 290 • Snellville, GA 30078 • (770) 972-0330

PRENATAL RECORD

Name: _____ Age: _____ Date of Birth: _____

MENSTRUAL HISTORY: First day of menstrual period: _____ Was it Normal? Yes ☐ No ☐
Type of last birth control: _____ Last used? _____

YOUR PERSONAL PRIOR MEDICAL HISTORY	0 NEG √ POS	REMARKS	HISTORY SINCE YOUR LAST MENSTRUAL PERIOD	0 NEG. √ POS	REMARKS
Heart Disease/Murmurs			Nausea/Vomiting		
High Blood Pressure			Indigestion/Constipation		
Asthma, Tuberculosis			Headache		
Stomach or Bowel Disease/Hepatitis			Bleeding (Specify)		
Bladder/Kidney Disease/Infections, Stones			Vaginal Discharge		
Gonorrhea/Chlamydia/Syphilis			Swelling		
Genital Warts or Herpes			Abdominal Pain		
Gyn. Disorder/Gyn. Surgery			Urinary Problems		
DES Exposure/Abnormal Paps			Viral Infection		
Nervous and Mental Problems			Other Illness/Fever		
Diabetes/Thyroid Problems			X-rays		
Blood Clots in Legs or Lungs			Accidents		
Seizures or Neurological Disorder			Medications/including OTC		
Drug Allergies			Tobacco Use		☐ Pt Counseled
Drug Abuse/History of Use			Drug Use		☐ Pt Counseled
Blood Disease/Transfusions			Alcohol Use		☐ Pt Counseled
Cancer/Other Medical Problems			HIV Exposure		☐ Pt Counseled
Rh, ABO Sensitivity			Cats/Raw Meats (Toxo Risks)		☐ Pt Counseled
Operations, Accidents, Hospitalization			Other		
Anesthetic Complications			Tattoos		
Have you had Chicken Pox?					

PREVIOUS PREGNANCIES: Full Term ____ Premature ____ Abortion/Miscarriage/Ectopic/Mole ____ Now Alive ____ Multiple Births ____

No.	Year	Hospital	Length of Pregnancy	Length of Labor	Type of Delivery	Type of Pain Relief	Weight Of Child	Complications		Comments/ Sex of Child
								Mother	Child	

GENETICS SCREENING: DO YOU, YOUR BABY'S FATHER, OR ANYONE IN EITHER FAMILY ...

	YES	NO		YES	NO
1. PATIENT'S AGE MORE THAN 35 YRS. OLD			11. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
2. NEUTRAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE, OR ANENCEPHALY)			12. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
3. DOWN SYNDROME			13. GREATER THAN 3 MISCARRIAGES OR ANY STILLBIRTHS		
4. TAY-SACHS (EG, JEWISH BACKGROUND)			14. MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD (INCLUDING OTC MEDS)		
5. SICKLE CELL DISEASE OR TRAIT			15. CLEFT LIP, CLEFT PALATE, CLUB FEET		
6. HEMOPHILIA			16. OTHER SIGNIFICANT FAMILY HISTORY (SEE COMMENTS)		
7. MUSCULAR DYSTROPHY			17. HEARING LOSS FROM BIRTH		
8. CYSTIC FIBROSIS			18. SUDDEN INFANT DEATH SYNDROME		
9. HUNTINGTON CHOREA			19. BIRTH DEFECTS		
10. MENTAL RETARDATION / FRAGILE X					

COMMENTS/REQUESTS: _____

GWINNETT OB/GYN ASSOCIATES, P.C.
Gynecology Questionnaire

NAME:_____ DATE:_____

DATE OF BIRTH:_____

REASON FOR VISIT: (If not routine, briefly describe main symptoms.) _____

_____

PAST MEDICAL HISTORY:

List all operations you have had.

	OPERATION	DATE
A.		
B.		
C.		
D.		
E.		
F.		

List all illnesses you have had that required hospitalization.

	ILLNESS	DATE
A.		
B.		
C.		
D.		
E.		
F.		

Have you ever had? (Check yes or no and give dates.)

YES	NO	ILLNESS	DATE
( )	( )	Migraine Headaches	
( )	( )	Thyroid Disorder	
( )	( )	Pneumonia	
( )	( )	Tuberculosis	
( )	( )	Heart Murmur	
( )	( )	High Blood Pressure	
( )	( )	Rheumatic Fever	
( )	( )	Diabetes	
( )	( )	German Measles or Vaccine	
( )	( )	Anemia	
( )	( )	Convulsions or Seizures	
( )	( )	Ulcers	
( )	( )	I will accept blood products if necessary	

YES	NO	ILLNESS	DATE
( )	( )	Jaundice of Hepatitis	
( )	( )	Kidney Stones	
( )	( )	Kidney Infection	
( )	( )	Bladder Infection	
( )	( )	Genital Herpes	
( )	( )	Gonorrhea	
( )	( )	Syphilis	
( )	( )	Broken Bones	
( )	( )	Arthritis	
( )	( )	Mental Illness	
( )	( )	Serious Injury	
( )	( )	Blood Transfusion	

Please list any additional medical conditions or illnesses:

ILLNESS	DATE

REVIEW OF SYSTEMS:
Are you currently having or have you recently had any of these symptoms? (Check "YES" or "NO")

A. GENERAL

YES	NO	
( )	( )	Recent weight gain
( )	( )	Recent weight loss
( )	( )	Depression
( )	( )	Headaches
( )	( )	Eye pain
( )	( )	Spots in front of eyes
( )	( )	Double vision
( )	( )	Glasses
( )	( )	Deafness
( )	( )	Nose bleeds

B. CHEST AND HEART

YES	NO	
( )	( )	Palpitation
( )	( )	Skipped or irregular heart beats
( )	( )	Chest discomfort on exertion
( )	( )	Chest pain with breathing
( )	( )	Shortness of breath with exertion
( )	( )	Awakening at night short of breath
( )	( )	Shortness of breath lying down
( )	( )	Coughing up blood

C. BREASTS

YES	NO	
( )	( )	Breast lump
( )	( )	Breast tenderness
( )	( )	Nipple discharge
( )	( )	Family history of breast cancer
( )	( )	Previous mammogram date _____

D. GASTROINTESTINAL

YES	NO	
( )	( )	Change in bowel habits
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Bright blood in stools
( )	( )	Clay colored stools
( )	( )	Black stools
( )	( )	Abdominal pain
( )	( )	Hemorrhoids
( )	( )	Vomiting up blood
( )	( )	Painful bowel movements
( )	( )	Nausea or vomiting

E. GENITO-URINARY

YES	NO	
( )	( )	Frequent or painful urination
( )	( )	Difficulty holding urine
( )	( )	Difficulty starting urine
( )	( )	Excessive urine
( )	( )	Frequent night urination
( )	( )	Change of color of urine
( )	( )	Blood or pus in urine
( )	( )	Wetting in bed

F. EXTREMITIES

YES	NO	
( )	( )	Varicose veins
( )	( )	Pain in legs when walking
( )	( )	Blood clots in legs
( )	( )	Skin rashes
( )	( )	New or growing moles

GWINNETT OB/GYN ASSOCIATES, P.C.

Gynecology Questionnaire (Sheet 2)

NAME: _____

MEDICATIONS: (List ALL medications that you take regularly or have taken recently, include all non-prescription drugs.)

1. _____ 3. _____

2. _____ 4. _____

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If YES, list which ones) _____

_____

_____

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	METHOD TYPE	DURATION OF USE	COMPLICATIONS
PRESENT			
PREVIOUS			

OBSTETRIC HISTORY: (List all pregnancies, dates, and outcomes.)

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.					
2.					
3.					
4.					
5.					
6.					

FAMILY HISTORY: (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family members, the cause of death and their ages at death.) _____

_____

_____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?

_____

_____

_____

SOCIAL HISTORY:

Do you smoke cigarettes? ☐ Yes No ☐ How many/day? _____ How many years? _____

Do you drink alcohol? ☐ Yes No ☐ How many drinks/day? _____ Per week? _____

Do you get any regular exercise? ☐ Yes No ☐ How often? _____

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY

First day of last period: _____ Age first started period: _____ Usual number of days from one period to the next: _____

Usual # of days of flow: _____ Are your periods: Light ☐ Moderate ☐ Heavy Any excessive bleeding or spotting between cycles? ☐ Yes No ☐

Cramps with periods? ☐ Yes No ☐ Depression, anxiety, emotional upset before periods? ☐ Yes No ☐

PAP SMEARS:

Last pelvic exam: _____ Last pap smear: _____ Have you ever had an abnormal pap? ☐ Yes No ☐

If yes, what treatment was done? _____ Have your paps been normal since treatment? ☐ Yes No ☐

Did your mother take hormones while pregnant with you? ☐ Yes No ☐

VAGINITIS:

Yeast: _____ Trichomonas: _____ Non-specific/Bacterial Vaginitis: _____

Are you having any problem with discharge now? ☐ Yes No ☐

SEXUAL HISTORY:

Any problems with pain? ☐ Yes No ☐ Any problem with Orgasm? ☐ Yes No ☐ Other? _____

Any history of STDs? HPV ☐ Yes No ☐ Herpes ☐ Yes No ☐ Syphilis ☐ Yes No ☐ Hepatitis ☐ Yes No HIV ☐ Yes No ☐

Gonorrhea ☐ Yes No Chlamydia ☐ Yes No ☐ Other? _____

List any Gynecologic surgeries, dates and reasons for surgery: _____

_____

_____

_____

_____

_____

Patient Account #_____

Acceptance of Blood Products

At Gwinnett OB/GYN we strive for optimum health and to preserve life. In the case of a life threatening emergency, **it is our policy to transfuse with blood if it is necessary to save your life.**

Please sign one of the below:

I understand and **agree** with the above transfusion policy.

_____

Print Name Signature Date

_____

Witness Signature Date

I **disagree** and will be transferring my care elsewhere.

_____

Print Name Signature Date

_____

Witness Signature Date

Updated 11/7/19

Gwinnett OB·GYN ASSOCIATES

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Ujuka Iloabuchi, M.D.
Anna Carter, M.D.
Jasmine Hawkins, M.D.
Laura Bono, RNC, WHNP
Mercy Manga, DNP, WHNP

Name: _____ Date: _____

Date of Birth: _____

Contact Phone Number: _____

Have you traveled outside of the United States in the past 12 weeks?

YES_____ NO_____

If yes, where? _____ When? _____

Have you traveled outside the country at any time during this pregnancy?

YES_____ NO_____

If yes, where? _____ When? _____

Has/Have your partner(s) traveled outside of the United States during your pregnancy?

YES_____ NO_____

If yes, where? _____ When? _____

The CDC recommends against traveling to any South or Central American countries including the Caribbean and Mexico during pregnancy.

If you answered "yes" to any of the above questions, please discuss with your physician or nurse practitioner during your visit today.

Despite the above recommendation, if you are planning to travel to any of the above areas please notify your OB provider.

_____ _____

Signature Date

1700 Tree Lane • Suite 290 • Snellville, Georgia 30078
Phone: 770/972-0330 • Fax: 770/985-2683 • www.gwinnettobgyn.com

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PATIENT'S CONFIDENTIALITY INSTRUCTIONS

Patient Name _____ Acct# _____

It is important for us to honor the confidentiality between patient and physician.
PLEASE CHECK YOUR PREFERENCE BELOW.

_____ You may discuss my medical information ONLY with me.

_____ I give my permission to discuss my medical information with the following people:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Yes or No (circle one) You may leave medical information (test results) on my voice mail at:

Cell # _____

Home # _____

Signed _____ Date _____

Patient Name: _____

Date of Birth: _____

We are now sending prescriptions electronically to patient pharmacies. In order for us to be able to do this we will need your pharmacy information. Please fill out the information below.

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Telephone Number: _____

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PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Our treatment relationship is a partnership, and we look forward to helping you achieve the best health outcomes possible.

First Time Visit: Please arrive at least ***30 minutes*** prior to your appointment time. An assistant will go over your past medical history at the time of your visit. Please bring all your medications in their original containers.

Follow-Up Visits: Please arrive ***15 minutes*** before your scheduled appointment time. It is our goal for you to be ready to see your physician on time. Notify us if you have any changes in your insurance or contact information. Please make us aware of any significant updates in your medical history, such as hospital or urgent care visits, and any changes in your medications by another healthcare provider.

Follow-up Care: Your treatment plan may involve follow-up care. As such, we may schedule you for diagnostic tests, follow-up appointments with us or other providers. If you do not keep the appointment, it is important that you contact us to discuss alternatives. Likewise, if you decide to seek care from another provider, please let us know. It is our policy to inform you of test results, however, if you have not received your test results within the expected time, please contact our office.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back into the schedule. Depending on how busy we are, you may be required to reschedule your appointment. Please note, we have a 15-minute grace period *(this does not apply to Ultrasound or Procedure appointments due to the extent of these visit types. Please be sure to arrive before or at your scheduled Ultrasound/Procedure appointment time).*

Cancellations for Office Appointments: We ask that you cancel and/or reschedule appointments *at least* ***24 hours*** in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 1 appointment without following the cancellation protocol, you will be charged **$50.00** for a missed office visit, **$75** for a missed ultrasound visit and **$100** for a missed procedure.

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If you miss 2 appointments without following the cancellation protocol, you must settle your past due no-show fee balance ***prior*** to scheduling any future appointments.

Surgery Cancellations:
If you are scheduled for surgery, we ask that you reschedule/cancel at least ***3 weeks*** prior to your surgery. If you reschedule or cancel your scheduled surgery in less than ***3 weeks***, you will be charged **$150** that will be billed directly to you.

Problem Visits: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to see another provider. ***Please do not visit if you are sick, have flu or cold-like symptoms, or any other illness.***

Visitors Policy:

- Only ***ONE*** support person over the age of 18 is allowed to attend a visit with patient.
- Newborns are allowed at post-partum visit only. Otherwise, no children are allowed.
- All patients & visitors should be healthy. **Please do not visit if you are sick, have flu or cold-like symptoms, or any other illness.**

Mask Policy:

- Masks are optional for patients who are fully vaccinated. **Please do not visit if you are sick, have flu or cold-like symptoms, or any other illness.**

Photography, Video and Audio Policy: For the protection of patients and staff privacy, photography, video, and audio recording are strictly prohibited without expressed permission.

Financial Policy:

- It is required that you bring your current and valid insurance card and driver's license, or government issued ID card to **EACH** visit.
- If you cannot provide valid insurance at the time of scheduling your appointment for our team to verify active coverage **PRIOR** to your visit, you will be considered as a self-pay patient and responsible for all charges at the time of your visit.
- If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. Payment is due at the time of service.
- Please note that we are contractually obligated to collect your co-pays or estimated deductible at the time of service.
- Notify us if you have any changes in your insurance or contact information.

Gwinnell OB·GYN
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After Clinic Hours and Weekends: You may reach the on-call physician by calling 770-972-0330 and our after-hour service center will assist you in reaching the on-call physician.

We respectfully request that you turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

_____ _____

Print Name **Sign Name**

_____

Today's Date

UPDATED: MARCH 2024

Gwinnett OB/GYN Associates, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name_____

Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed and a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

_____

- Other: _____

_____

Prepared by: _____
Signature: _____
Date: _____

GWINNETT OB-GYN ASSOCIATES, P.C.

DATE: _____

PATIENT INFORMATION

Patient Name: First_____ MI_____ Last_____ SS# _____

Address: _____ City_____ St_____ Zip _____ DOB: _____

Phone: Home_____ Cell_____ Work_____

E-Mail_____ By providing your email address you agree to receive (check to agree) ☐ Appointment Reminders

Best Contact Method: ☐ Home ☐ Cell ☐ Work ☐ E-Mail ☐ Mail Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

INSURANCE INFORMATION

Primary Insurance Name: _____ Group #_____ Member ID#_____

Address: _____ City_____ St_____ Zip _____

Secondary Insurance Name: (If applicable)_____ Group #_____ Member ID#_____

Address: _____ City_____ St_____ Zip _____

☐ **Check if same as Patient Information** *(If different, please complete section below)*

Policy Holders Name: _____ DOB: _____ SS# _____

Relationship (circle one): Spouse Parent Guardian Other (Please Specify): _____

Phone: Home_____ Cell_____ Work_____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

REFERRAL SOURCE

☐ Friend/Family Member _____ ☐ Walk-in ☐ Magazine ☐ Web Search ☐ Practice Website ☐ Event

☐ Another Physician/Provider (name & phone number) _____ ☐ Other Advertisement _____

☐ Other _____ ☐ Hospital _____

I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services rendered at time of service. I understand that I am financially responsible for all services rendered at the time of service. There is a $30 returned check fee and that 30% will be added to my balance if my account must be referred to an agency for collection. Additionally, I understand that if I am covered by any insurance that requires a referral number, it is my responsibility to obtain that referral number prior to my visit. It is also my responsibility to obtain any medical records prior to my appointment if referred by an outside physician.

Signature_____ Date _____