Patient Name *

Date of Birth *

mm-dd-yyyy

Date

Congratulations on your pregnancy!

We are excited to be providing your Obstetrical care at Alliance ObGyn. We encourage you to begin taking an over the counter prenatal vitamin that is high in folic acid.

For routine OB care:

- Most patients will be seen first around 7-9 weeks for a Confirmation of Pregnancy Ultrasound and Provider visit. This visit will be followed by an Intake appointment with our RN between 8-10 weeks.
- Following the RN Intake visit, you will see your doctor for your Initial OB visit around 11-12 weeks - this is the first opportunity to listen to the heartbeat by Doppler.

If you are experiencing any issues prior to your scheduled appointments, please call or text our office at 517-484-3000 and we will be happy to schedule a Doctor's visit for you. Please be aware that any appointments related to your pregnancy prior to your Nurse Intake visit may be billed as a separate office visit and may be subjected to your standard Copay or Deductible.

To help us provide you with the best care, we ask that you please take a moment to answer the following questionnaires. Failure to complete this paperwork 48 hours prior to your appointment may result in rescheduling.

OB Screening and Testing Information

Disease Screening: The Physicians and Midwives at Alliance Obstetrics & Gynecology in addition to The American College of Obstetricians and Gynecologists (ACOG) and the Michigan Department of Health and Human Services (MDHHS) recommend that all pregnant women undergo testing for HIV, Syphilis, Hepatitis B, Hepatitis C, Urine Drug Screen, Gonorrhea and Chlamydia. This is universal testing and not based on risk factors. If you don't do

these tests during pregnancy, your pediatrician will recommend additional screening and treatments for your newborn.

*

- ◯ I agree to recommended screenings.
- ◯ I decline the recommended screenings.

Please answer the following questions about your personal history as well as your family history.

Pregnancy History Form

Do you or the baby's father have a personal or family history of *

	Yes	No
Spina Bifida (open spine)	◯	◯
Hemophilia	◯	◯
Muscular Dystrophy	◯	◯
Cystic Fibrosis	◯	◯
Blood clots	◯	◯
Sickle cell anemia or carrier status	◯	◯
Ashkenazi Jewish Ancestry	◯	◯
Two or more miscarriages	◯	◯
Congenital heart defect	◯	◯
Mental Impairment	◯	◯
Other genetic or chromosomal issue	◯	◯

***If yes, please provide details:**

Mother's Race *

- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Unreported/Refuse to Report

Mother's Ethnicity *

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to report

Race and ethnicity of the father of the baby:

Please complete the following table about your PERSONAL pregnancy history.

	Miscarriage, termination, or type of delivery	Weeks gestation at delivery/end of pregnancy	Infant's Birth Weight	Complications (with pregnancy or delivery)	Place of delivery/delivering physician	Gender	Name
First pregnancy							
Second pregnancy							
Third pregnancy							
Fourth pregnancy							
Fifth pregnancy							
Sixth pregnancy							

In the past year, how often have you used the following: *

	Never	Once or twice	Monthly	Weekly	Daily or almost daily
Alcohol, 4 or more drinks per day	◯	◯	◯	◯	◯
Tobacco products	◯	◯	◯	◯	◯
Prescription drugs for non-medical reasons	◯	◯	◯	◯	◯
Illegal Drugs	◯	◯	◯	◯	◯

Treatment and Testing During Pregnancy

During your pregnancy, you will be scheduled for routine visits with providers at Alliance OB/GYN. These appointments allow your provider to monitor the health of you and your baby. They also allow your provider to screen for potential complications that may occur in pregnancy, and intervene as early as possible to ensure the best possible outcome for you and your baby.

Additional tests in the form of blood work, ultrasounds, and/or fetal monitoring may be ordered based on your personal history or the way your pregnancy is progressing. Your provider will discuss the purpose of these tests with you in detail and will answer any questions that you may have.

If you are unable to come in for your scheduled appointment for any reason, we encourage you to reschedule as soon as possible. If you do not want to keep your recommended appointments for either routine visits or testing, you will be encouraged to schedule an appointment to discuss your decision with your provider.

All appointments and tests are to promote the healthiest outcome for you and your baby. Failure to keep any appointments, including ultrasound or monitoring, may seriously jeopardize your health and your baby's health. This may lead to increased illness or even death of you or your baby.

Signature *

Clear

Delivery at Sparrow Hospital: We have multiple Alliance Physicians covering Sparrow Hospital to provide care during your delivery and hospital stay. You can learn more about each of us on our website under the Providers page. Although we cannot predict which Alliance provider will be on call the day of your delivery, we do know that you will get exceptional care. We have an Alliance Birth Partnership that reviews our standard of care for delivery.

How to Contact Us: If you have a non-urgent medical question that cannot wait until your next appointment, please contact our nurses through your Alliance Patient Portal. We are also available by phone for urgent medical issues. The operator will send your information to the nurses and you will receive a phone call back. For emergent issues, head directly to the hospital.

Patient Demographic Information

Patient's last name: *

First: *

Middle:

Preferred to be called:

Is this your legal name? *

- Yes
- No

If not, what is your legal name?

(Former name):

Marital Status *

- Single
- Married
- Divorced

Birth date: *

mm-dd-yyyy

Date

Age: *

Sex: *

- Male
- Female

Street Address: *

P.O. Box / Apt #:

City: *

State: *

Zip Code: *

Cell Phone:

Home Phone:

Social Security Number:

Email Address:

Employer:

Employer Phone:

Race *

- [ ] Asian
- [ ] Native Hawaiian
- [ ] Other Pacific Islander
- [ ] Black/African American
- [ ] White
- [ ] Unreported/Refuse to Report
- [ ] More than one race

Ethnicity *

- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino
- [ ] Refused to report

Language:

Preferred Notification Method: *

- ( ) Phone
- ( ) Postal Mail
- ( ) Portal

Family Physician First Name: *

Family Physician Last Name: *

Family Physician Phone:

Referring Physician First Name:

Referring Physician Last Name:

Referring Physician Practice:

Referring Physician Phone:

Insurance Information

Upload pictures of the front and back of your insurance card.

Browse Files

You can select multiple files

PRIMARY INSURANCE: *

Subscriber's Name: *

Subscriber's Date of Birth: *

mm-dd-yyyy

Date

Patient relationship to subscriber: *

If patient is a minor, Name of Guarantor

If patient is a minor, Guarantor's Date of Birth

mm-dd-yyyy

Date

Enrollee, Subscriber or Policy ID # *

Subscriber's Employer: *

SECONDARY INSURANCE:

Secondary Insurance Subscriber's Date of Birth:

mm-dd-yyyy

Date

Secondary Insurance Patient relationship to subscriber:

Secondary Insurance Subscriber's Name:

Secondary Insurance Enrollee, Subscriber or Policy ID #

Secondary Insurance Subscriber's Employer:

Do you have a Secondary Medicaid Insurance Plan? *

- ◯ Yes
- ◯ No

If you pick up a secondary Medicaid plan during your pregnancy, it is your responsibility to inform Alliance OBGYN. Please note that Alliance OBGYN does not bill Medicaid. However Sparrow Hospital will bill Medicaid for their portion of your delivery/services. Therefore it is important to let our team know if you have Secondary Medicaid coverage.

Emergency Contact

Name of local friend or relative: *

Relationship to patient: *

Cell Phone:

Home Phone:

Work Phone:

I hereby authorize the release of any medical information necessary to process my insurance claim. I authorize payment to be made directly to Alliance Obstetric and Gynecology. I have been provided with a copy of the Alliance Financial Policy and understand that I am financially responsible for any balance not covered by my insurance carrier.

Please review the Alliance Patient Financial Policy.

Name *

First Name Last Name

Signature *

Clear

Medical History

Please check all that apply to you.

Breast

- [ ] Breast Lump (benign)
- [ ] Breast Cancer
- [ ] Fibrocystic Disease of the breast
- [ ] Cyst of the Breast
- [ ] Nipple discharge
- [ ] Mastitis
- [ ] Breast Infection

Cancer

- [ ] Brain Cancer
- [ ] Cervical Cancer
- [ ] Colon Cancer
- [ ] Lung Cancer
- [ ] Ovarian Cancer
- [ ] Rectal Cancer
- [ ] Skin Cancer*
- [ ] Stomach Cancer
- [ ] Thyroid Cancer
- [ ] Uterine Cancer
- [ ] Other Cancer**

***Type:**

****Type:**

Cardiovascular

- [ ] Blood Clot
- [ ] Heart Disease
- [ ] Hypertension
- [ ] Hypercholesterolemia
- [ ] Peripheral Vascular Disease
- [ ] Pulmonary Embolism

- [ ] Raynaud's Syndrome
- [ ] Rheumatic Heart Disease
- [ ] Heart Problem*

***Type:**

Dermatological

- [ ] Acne
- [ ] Ulcer of the skin
- [ ] Lupus

Endocrine

- [ ] Goiter
- [ ] Graves' Disease
- [ ] Hashimoto Thyroiditis
- [ ] Hypothyroidism
- [ ] Partial Thyroidectomy
- [ ] Full Thyroidectomy
- [ ] Gestational Diabetes
- [ ] Insulin Dependent Diabetes
- [ ] Non-Insulin Dependent Diabetes
- [ ] Polycystic Ovarian Disease

Gastrointestinal

- [ ] Cholelithiasis
- [ ] Crohn's Disease
- [ ] Diverticulitis of the colon
- [ ] Cirrhosis of Liver
- [ ] Gastric Ulcer
- [ ] Irritable Bowel Syndrome (IBS)
- [ ] Ulcerative Colitis
- [ ] Acure Hepatitis
- [ ] Viral Hepatitis A
- [ ] Viral Hepatitis B
- [ ] Viral Hepatitis C
- [ ] Hemorrhoids

Genitourinary

- [ ] Endometriosis
- [ ] Infertility
- [ ] Ovarian Cyst
- [ ] Kidney Disease
- [ ] Chronic Cystitis
- [ ] Kidney Stones
- [ ] Gonorrhea
- [ ] Chlamydia
- [ ] Lichen Sclerosis
- [ ] Premenstrual Dysthymic Disease
- [ ] History of Abnormal Pap*
- [ ] Interstitial Cystitis
- [ ] Pelvic Inflammatory Disease (PID)
- [ ] Genital Warts
- [ ] Herpes-Genital

***Type:**

Menstrual History

- [ ] Bleeding or spotting between periods

Last menstrual period: *

How heavy is your flow during periods? *

- [ ] Light
- [ ] Moderate
- [ ] Heavy

Please answer the following questions: *

	Yes	No
Do you have clotting during your periods?	◯	◯
Do you have painful cramping during your periods?	◯	◯

HEENT **Hematological** **Musculoskeletal**

- [ ] Deafness
- [ ] Blindness
- [ ] Glaucoma
- [ ] Migraine with aura
- [ ] Migraine w/o aura
- [ ] Anemia
- [ ] Sickle Cell Anemia
- [ ] DVT/Pulmonary Embolism
- [ ] Hemophilia
- [ ] Von Willebrand's Disease
- [ ] Thrombophilia or clotting disorder
- [ ] Arthritis
- [ ] Fibromyalgia
- [ ] Osteopenia
- [ ] Osteoporosis

Neurological

- [ ] Migraine
- [ ] Migraine with aura
- [ ] Multiple Sclerosis
- [ ] Parkinson's Disease
- [ ] Myasthenia Graves
- [ ] Stroke
- [ ] Seizure Disorder

Psychiatric

- [ ] Alcohol Abuse
- [ ] Anorexia Nervosa
- [ ] Anxiety Disorder
- [ ] Depression
- [ ] OCD
- [ ] Schizophrenia
- [ ] Suicide Attempt
- [ ] Post-Partum Depression
- [ ] Bulimia Nervosa
- [ ] Borderline Personality Disorder

Respiratory

- [ ] Asthma
- [ ] COPD
- [ ] Sleep Apnea

Surgical History

Have you ever had any surgeries? *

- ( ) Yes
- ( ) No

List the year for ALL procedures that apply to you. List ALL OTHER surgeries at the bottom.

	Year(s)
D&C	
Ovarian Surgery *give details below	
Hysteroscopy Removal of Polyp	
Hysteroscopy Removal of Fibroid	
Laparoscopy	
Myomectomy	
Infertility Surgery	
Vulvar Surgery **give details below	
Hysterectomy - Vaginal †give details below	
Hysterectomy - Abdominal ‡give details below	

Cesarean Section	
Tubal Ligation (tubes tied)	
Vaginal or Bladder Repaid for Prolapse or Incontinence	
Endometrial Ablation	

Other surgery, type & date

Other surgery, type & date

Other surgery, type & date

***Type of Ovarian Surgery:**

****Type of Vulvar Surgery:**

†If yes, do you:

- [ ] Still have cervix
- [ ] Still have both ovaries
- [ ] Still have one ovary

‡If yes, do you:

- [ ] Still have cervix
- [ ] Still have both ovaries
- [ ] Still have one ovary

Allergies to Medications

Do you have allergies to medications? *

- ◯ NO, I do not have allergies to medications
- ◯ YES, I have allergies to medications as listed below

List the medications to which you are allergic, followed by your reaction to those medications:

Other Allergies: *

	Yes	No
Iodine Allergy	◯	◯
Latex Allergy	◯	◯

Current Daily Medications, Vitamins, Over the Counter Supplements and Medical Devices

Please fill out the following table:

	Medication	Dose (amount)	Frequency (how often taken)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Family History

Indicate which, if any, family members have had the following conditions:

	Mother	Father	Brother	Sister	Son	Daughter	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Diabetes - Insulin Dependent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes - Non-Insulin Dependent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clots (leg/lungs)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thrombophilia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social / Sexual History

Do you have a history of abuse? *

- ◯ Yes
- ◯ No

Are you currently being abused? *

- ◯ Yes
- ◯ No

History of abuse: Check all that apply. *

- ☐ Physical
- ☐ Mental
- ☐ Verbal
- ☐ None

Are you currently using tobacco (chewing or smoking)? *

- ◯ Yes
- ◯ No

Tobacco: Amount

Tobacco: How frequently?

Are you exposed to second hand smoke? *

- ◯ Yes
- ◯ No

Second Hand Smoke Exposure: How frequently?

Second Hand Smoke Exposure: Type

Are you currently using alcohol? *

- ◯ Yes
- ◯ No

Alcohol: How frequently?

Alcohol: Amount

Are you currently using illicit drugs? *

- ◯ Yes
- ◯ No

Illicit Drugs: Type

Illicit Drugs: Amount

Are you currently using birth control? *

- ◯ Yes
- ◯ No

Birth Control: Type (i.e. IUD, pills, condom, etc)

Are you currently exercising? *

- ◯ Yes
- ◯ No

Exercise: How often?

Exercise: Type

Marital Status: *

Living Situation: *

Occupation: *

Additional questions: *

	Yes	No
Are there religious beliefs affecting medical care?	◯	◯
Are you agreeable to receiving blood/blood products?	◯	◯

Please answer the following questions: *

	Yes	No
Do you wear a helmet?	◯	◯
Do you wear a seat belt?	◯	◯

Have you ever been sexually active? *

- ◯ Yes
- ◯ No

Are you currently sexually active? *

- ◯ Yes
- ◯ No

Number of sexual partners currently: *

Please indicate, are you sexually active with: *

- ◯ Male
- ◯ Female
- ◯ Both
- ◯ Decline

Please specify any other relevant information:

History of Pregnancy

If you have never been pregnant, please enter 0 in those fields.

Please list your total number of: *

	Number
Pregnancies	
Deliveries	
Pre-Term Deliveries	
C-Sections	
Miscarriages	
Abortions	
Live Births	
Ectopic Pregnancy	

Have you had any of the following during pregnancy:

- [ ] Gestational Diabetes
- [ ] Preeclampsia
- [ ] Multiple Gestation Twins
- [ ] Multiple Gestation Triplets
- [ ] Fetal Demise
- [ ] Placental Abruption
- [ ] Hemorrhage
- [ ] Pre-Term Labor
- [ ] Other

Immunizations

Indicate the date of your last immunization. If you are unaware of the date or have not had, please indicate with N/A. *

	Date
Tetanus Shot	
MMR Shot (measles)	
Flu Shot	
Pneumonia Shot	
Shingles Shot	
Varicella (chicken pox) Shot	
Gardasil (cervical cancer) Shot	

Health Maintenance

Please fill out the following table: *

	Date	Result	N/A
Last Mammogram			
Last Colonoscopy			
Last Bone Density			
Last Pap			
Last HPV			

If you've ever had an abnormal pap, in what year?

If you've ever had treatment for an abnormal pap smear, what type of treatment have you had?

Have you ever had treatment for any of the following?

	Year
Cryotherapy	
Laser	
Cone Biopsy	
Loop excision (LEEP)	

Have you had a BRCA screening (blood test for breast cancer gene)? *

- ○ Yes
- ○ No

Do you need assistance with your visit? (i.e. wheelchair, interpreter service, etc):

Submit