



9. How many pregnancies (including abortions, and this pregnancy) have you had? \_\_\_\_\_

10. Were there any complications during or after your pregnancies?  
Preterm labor, preeclampsia, diabetes, other?  Yes  No  
If yes, please explain: \_\_\_\_\_

11. Past pregnancies: In the following table, list all pregnancies, including births, miscarriages, and abortions.

Date (mo/yr)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Weeks Gestation	Length of Labor	Birth Weight	Sex (M/F)	Anesthesia	Place of Birth

12. When was the first day of your last period? \_\_\_\_\_

13. Was your last menstrual period normal?  Yes  No

14. Are your periods regular?  Yes  No

15. Were you using any form of contraception at the time of conception?  Yes  No  
If yes, which one? \_\_\_\_\_

16. If you have been on oral contraceptive pills within the last year, when did you stop taking the pills? \_\_\_\_\_

**PRENATAL GENETIC SCREEN**

17. Will you be 35 or older when your baby is due?  Yes  No

18. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?

Down syndrome (Mongolism)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other chromosomal abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neural tube defect, i.e. Spina Bifida (Meningomyelocele or Open Spine), Anencephaly	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, indicate the person related to you or the baby's father:  
\_\_\_\_\_

19. Do you or your baby's father have a birth defect?  Yes  No  
If yes, who has the defect and what is it? \_\_\_\_\_
20. In any previous marriages, have you or the baby's father had a child born, dead or alive, with a birth defect not listed in the question above?  Yes  No  
If yes, please explain \_\_\_\_\_
21. Do you or the baby's father have any close relatives with mental retardation?  Yes  No  
If yes, indicate the relationship of the affected person to you or the baby's father:  
\_\_\_\_\_  
Indicate the causes, if known. \_\_\_\_\_
22. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder or chromosomal abnormality not listed above?  Yes  No  
If yes, indicate the condition and the relationship of the affected person to you or the baby's father:  
\_\_\_\_\_
23. In any previous marriage, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses?  Yes  No
24. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?  Yes  No  
If yes, indicate who and the results: \_\_\_\_\_
25. If you or the baby's father are black, have either of you been screened for sickle cell trait?  Yes  No  
If yes, indicate who and the results: \_\_\_\_\_
26. If you or the bay's father are of Italian, Greek, or Mediterranean background, have either of you been tested for Thalassemia?  Yes  No  
If yes, indicate who and the results: \_\_\_\_\_
27. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for Thalassemia?  Yes  No  
If yes, indicate who and the results: \_\_\_\_\_
28. Excluding iron and vitamins, have you taken any medications or recreational drugs since becoming pregnant or since your last menstrual period? (Include prescription drugs)  Yes  No  
If yes, give name of medication and time taken during pregnancy \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL ASSESSMENT SCREEN**

29. Have you ever been emotionally or physically abused by your partner or someone important to you?  Yes  No

30. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?  Yes  No

If yes, by whom? (Circle all that apply)

Husband      Ex-husband      Boyfriend      Stranger      Other      Multiple

Extent of injury (Mark all that apply)

- Threats of abuse, including use of a weapon
- Slapping, pushing, no injuries and/or lasting pain
- Punching, kicking, bruising, cuts, and/or lasting pain
- Beaten up, severe contusions, burns, broken bones
- Head, internal, and/or permanent injury
- Use of weapon, wound from weapon

31. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?  Yes  No

If yes, by whom? (Circle all that apply)

Husband      Ex-husband      Boyfriend      Stranger      Other      Multiple

Extent of injury (Mark all that apply)

- Threats of abuse, including use of a weapon
- Slapping, pushing, no injuries and/or lasting pain
- Punching, kicking, bruising, cuts, and/or lasting pain
- Beaten up, severe contusions, burns, broken bones
- Head, internal, and/or permanent injury
- Use of weapon, wound from weapon

32. Within the last year, has anyone forced you to have sexual activities?  Yes  No

If yes, by whom? (Circle all that apply)

Husband      Ex-husband      Boyfriend      Stranger      Other      Multiple

33. Are you afraid of your partner or anyone you listed above?  Yes  No

34. Please list any additional information or concerns that you may have in regards to this pregnancy.

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### CONSENT FOR PRENATAL ULTRASOUNDS / TESTING

I understand that ultrasound examinations may be recommended by Contemporary OBGYN of Western Kentucky. I understand that these exams are used to help reassure me that the baby is growing as expected and provide my provider reassurance that the baby is doing well.

Additionally, they are used to help establish my due date, look at the baby's developing organs and provide information about other potential problems with the baby, the amniotic fluid and placenta which may affect mine or my baby's health. Furthermore, additional testing is recommended for infectious diseases per the American College of Obstetricians & Gynecologists including Human Immunodeficiency Virus, hepatitis, syphilis and toxicology screening as these can be associated with increased risk of miscarriage, poor fetal growth, fetal abnormalities as well as numerous other problems that could potentially effect my health or my baby's health.

I realize that although ultrasounds may detect many possible problems, they do not detect ALL problems and a normal ultrasound does not ensure a completely normal baby without any problems or birth defects due to the limits of the study.

I have given Contemporary OBGYN of Western Kentucky permission to perform the necessary screening today and at any other time during my pregnancy when it may become necessary. Insurance policies vary, and it is the patient's responsibility to know their benefits. I understand that I am responsible to pay for any ultrasounds that are not covered by my insurance.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

2601 Kentucky Avenue  
Doctors Building One, Suite 103  
Paducah, Kentucky 42003

Contemporary  
**OB/GYN**  
+ of Western Kentucky  
Susan K. Mueller, M.D.



270.444.9199  
Toll Free 877.441.9199  
Fax 270.444.9299  
www.kentuckyobgyn.com

Name: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_

Baby's Date of Birth: \_\_\_\_\_

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time      This would mean: "I have felt happy most of the time" during the past week.
- No, not very often      Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- 1. I have been able to laugh and see the funny side of things
  - As much as I always could
  - Not quite so much now
  - Definitely not so much now
  - Not at all
- 2. I have looked forward with enjoyment to things
  - As much as I ever did
  - Rather less than I used to
  - Definitely less than I used to
  - Hardly at all
- \*3. I have blamed myself unnecessarily when things went wrong
  - Yes, most of the time
  - Yes, some of the time
  - Not very often
  - No, never
- 4. I have been anxious or worried for no good reason
  - No, not at all
  - Hardly ever
  - Yes, sometimes
  - Yes, very often
- \*5. I have felt scared or panicky for no very good reason
  - Yes, quite a lot
  - Yes, sometimes
  - No, not much
  - No, not at all
- \*6. Things have been getting on top of me
  - Yes, most of the time I haven't been able to cope at all
  - Yes, sometimes I haven't been coping as well as usual
  - No, most of the time I have coped quite well
  - No, I have been coping as well as ever
- \*7. I have been so unhappy that I have had difficulty sleeping
  - Yes, most of the time
  - Yes, sometimes
  - Not very often
  - No, not at all
- \*8. I have felt sad or miserable
  - Yes, most of the time
  - Yes, quite often
  - Not very often
  - No, not at all
- \*9. I have been so unhappy that I have been crying
  - Yes, most of the time
  - Yes, quite often
  - Only occasionally
  - No, never
- \*10. The thought of harming myself has occurred to me
  - Yes, quite often
  - Sometimes
  - Hardly ever
  - Never

# Contemporary OB/GYN

Susan K. Mueller, M.D.

of Western Kentucky

## PATIENT REGISTRATION

### PATIENT INFORMATION

Name \_\_\_\_\_ Former Name \_\_\_\_\_  
*Last First MI*

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_  
*Street City State Zip*

Primary Phone # \_\_\_\_\_  Home  Cell

Secondary Phone # \_\_\_\_\_  Home  Cell

Marital Status  Single  Married  Divorced  Widowed

\_\_\_\_\_  
If married, spouses name

\_\_\_\_\_  
Financially responsible person (if under 18 years of age)

### PATIENT'S EMPLOYMENT INFORMATION

Employment Status  Full Time  Part Time  Retired  Unemployed

Employer's Name \_\_\_\_\_

Employer's Phone \_\_\_\_\_ May we contact you at work?  Yes  No

Student Status  Full Time  Part Time  Not a Student

### RELEASE OF MEDICAL INFORMATION

Please list the individuals that we are authorized to speak with regarding your care and/or account.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

By signing this statement, you release the staff of Contemporary OB/GYN of Western Kentucky from any and all liability from disclosing confidential information to the persons listed above. This may include, but is not limited to, information regarding HIV, sexually transmitted diseases, and sexual and psychological history.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referring Physician, if any \_\_\_\_\_

Emergency Contact _____	<i>Name</i>	<i>Relation</i>	<i>Telephone Number</i>
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Which pharmacy do you use most often? \_\_\_\_\_

How did you hear about us (Check all that apply)?

- The Paducah Sun
- Radio
- The Yellow Pages
- The Wright Pages
- Bridal Expo
- Real Women's Expo
- Baby Fair
- Health Department
- Magazine \_\_\_\_\_
- Physician(s) (Name) \_\_\_\_\_
- Friend(s) or Family Member(s) (Please tell us so that we may thank them!)

*Email* \_\_\_\_\_

Other \_\_\_\_\_

**PATIENT POLICIES**

We are very pleased to have you as our patient. These policies have been established so that we can give you the best care possible.

- If you are more than 15 minutes late for your scheduled appointment time, you will be asked to reschedule.
- We ask that you please give our office 24 hours notice of cancellation unless it is an emergent situation.
- After three "no show" visits in which we do not receive 24 hours notice, we will cease care.
- All co-payments are due at the time of service, unless other arrangements are made in advance.
- Self-pay patients are expected to pay in full at time of service, unless other arrangements are made in advance.
- It is ultimately the patient's responsibility to know which physicians and/or facilities are in network with their insurance company.

*I have read the above patient policies. I understand that it is my responsibility to contact a staff member for assistance of if I have any questions or concerns.*

Signature \_\_\_\_\_ Date \_\_\_\_\_



# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

### **OUR OBLIGATIONS**

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of our notice that this is currently in effect.

### ***How We May Use and Disclose Health Information***

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's Privacy Officer.

#### **Treatment**

We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

#### **Payment**

We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

#### **Health Care Operations**

We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose your medical information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

#### **Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.**

We may use and disclose your Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

#### **Individuals Involved in Your Care or Payment for Your Care.**

When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

### **SPECIAL SITUATIONS**

#### **As Required by Law**

We will disclose Health Information when required to do so by international, federal, state or local law.

#### **To Avert a Serious Threat to Health or Safety**

We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

#### **Business Associates**

We may disclose Health Information to our business associates that perform functions on our behalf to provide us with services if the information is necessary for such services to function. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

#### **Organ and Tissue Donation**

If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes or tissues to facilitate organ, eye, or tissue donation and transplantation.

#### **Military and Veterans**

If you are a member of the Armed Forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

#### **Workers' Compensation**

We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

#### **Public Health Risks**

We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and death; report child abuse or neglect; report reactions to medications or problems with products; notify people or recalls of products they may be using; informing a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

By my signature below, I acknowledge receipt and understanding of the Privacy Notice provided by Contemporary OB/GYN of Western Kentucky

Today's Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

# Contemporary OB/GYN of Western Kentucky

Susan K. Mueller, M.D.    Sherri DiCicco, ARNP    Meghan Lee, ARNP    Becky Johnson, CNM

February 2010

Dear Patient:

In light of revised Cervical Cancer Screening/Pap Smear Guidelines/Recommendations by the American Cancer Society (ACS) in November 2002 and the American Congress of Obstetrics and Gynecology (ACOG) in December, 2009, we are pleased to inform you we will be implementing these new Guidelines starting February 2010. We are also pleased to inform you that our practice will be providing patients with a test, *High-Risk HPV DNA*, designed to complement the Pap test. According to the ACS and ACOG, the incorporation of this test will provide extremely valuable insight in the early detection of cervical cancer and its precursors.

The new Pap Smear Guidelines according to ACOG (American Congress of Obstetricians/Gynecologists):

- Women should have their first screening pap smear at age 21 unless they have had previous abnormal result
- Women in their 20's can move their pap smears to every two years (with two previous consecutive normal pap smears)
- Women age 30 and older who have had three previous consecutive normal pap smears with negative HPV testing should have a pap smear every three years
- Women who have had a hysterectomy for non-cancerous reasons do not need a pap smear unless they have a cervix
- Women may cease having pap smears after age 65-70 so long as they have had normal pap smears for the last 10 years

Both the ACS and ACOG recommend yearly physical exams including a breast exam, pelvic exam (with or without a pap smear) and STI screening if indicated.

All women 24 years and younger should have annual STI screening.

You **MUST** have an annual exam including a breast and pelvic exam to receive birth control or hormonal therapy.

If you have **ever** had an abnormal Pap smear, consult with the provider performing your exam concerning how often you will need Pap smears.

You are probably familiar with the Pap test, but may not be familiar with the *High-Risk HPV DNA* test and the reasons why you should have this test performed along with your Pap test.

- HPV is a very common virus.
- Approximately 20 million people are currently infected with HPV. At least 50 percent of sexually active men and women acquire genital HPV infection at some point in their lives. By age 50, at least 80 percent of women will have acquired a genital HPV infection. About 6.2 million Americans get a new genital HPV infection each year. (Centers for Disease Control and Prevention, [www.cdc.gov](http://www.cdc.gov))
- Most women will successfully clear the virus soon after infection. If the virus isn't cleared by your immune system, it may cause abnormal changes to the cells of your cervix.
- The High-Risk HPV DNA test allows us to look for these abnormal cells indicating the possible presence of HPV, a virus that can progress to cervical cancer if undiagnosed or untreated.

We are aware that certain insurance plans will be reimbursing for this test, however, we cannot be sure your particular plan has included this test in your benefits.

- It is your responsibility to ascertain your plan coverage. The Current Procedural Terminology (CPT) Code for this test is 87621.
- We will try to help you with any questions you may have regarding your discussion with your insurance provider.

HPV testing is playing a growing role in cervical cancer screening programs and our practice is committed to providing you with the latest advancements that are available.

Thank you,

Susan K. Mueller, M.D.; Sherri DiCicco, ARNP; Meghan Lee, ARNP; Becky Johnson, CNM

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Name \_\_\_\_\_  
*Last First MI*

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_  
*Street City State Zip*

Primary Phone # \_\_\_\_\_

I do hereby authorize \_\_\_\_\_ to release:  
(Name of Facility)

My health information relating to the following treatment or condition: \_\_\_\_\_  
\_\_\_\_\_

My health information for the date(s): \_\_\_\_\_

Other: \_\_\_\_\_

I do  I do not authorize the release of information related to AIDS, HIV, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Release information to: \_\_\_\_\_  
*Name of Company/Agency/Facility/Person*

\_\_\_\_\_ *Street Address*

\_\_\_\_\_ *City State Zip Code*

Purpose of Disclosure:

- Referral to Specialist
- Insurance
- Personal
- Continuing Care
- Change of Doctor
- Other

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations.

\_\_\_\_\_  
Signature of Individual or Guardian

\_\_\_\_\_  
Date