PLYMOUTH FAMILY PHYSICIANS, S. C.
1000 EASTERN AVENUE
PLYMOUTH, WI 53073
PHONE: 920-893-0526
FAX: 920-893-8068

MARY E. ARENBERG, M. D. GEORGE S. SCHROEDER, M. D.

PATIENT'S NAME ____

DATE ____

The following is a long form requesting details of your health history and your pregnancy. This will assist us in providing thorough care and in obtaining needed services for your pregnancy. Even if this is not your first pregnancy or your first with Plymouth Family Physicians, we would like you to complete this to make sure that you are getting the best care possible for this current pregnancy.

PAST MEDICAL HISTORY:

1. Did you have any health problems at birth or in childhood?

2. Please list any hospitalizations and surgeries and if possible, the approximate dates:

3. Have you had a complete set of childhood immunizations?

4. Please list the date of your last tetanus shot:

5.Are you aware of any prior medical problems (please circle) including: diabetes, high blood pressure, heart disease, rheumatic fever, heart murmur, anemia, or blood clotting difficulty, kidney disease, urinary tract infections, significant head injuries or epilepsy, depression, jaundice, hepatitis, ulcer disease, heartburn, varicose veins, blood clots, thyroid abnormalities, blood transfusions.

COMMUNICABLE DISEASES

6. Have you ever been advised to have antibiotics before dental appointments or surgery?

7. Have you had any rashes or viral illnesses since your last menstrual period?

8. Do you have any history of exposure to tuberculosis or have you had a positive TB skin test?

9. Have you ever had any sexually transmitted infections ("STD")?

10. Do you eat wild game or raw meat?

11. Have you or your partners had a history of genital herpes?

12. You will be advised to have testing for the AIDS virus during your pregnancy according to the universal precautions recommended by the Center for Disease Control. As with all HIV testing, this will require your signature on a consent

form. We do confidential testing here, which means that the results are not linked with your chart or with your name, and are coded so that only you and your health care providers in this office will be aware of any result.

13. Do you have cats living in your home, and have you arranged for someone else to handle all cat litter?

MARITAL STATUS, PREGNANCY PLANNING, EDUCATION

1. Was your pregnancy planned?

2. Are you married, and if so, for how many years?

3. What is your hometown?

4. What was the last grade you completed in school?

5. What is your occupation, where do you work, and what hours?

6. What is the baby's father's name?
   Hometown:
   Age:
   Occupation, employer, work hours:

7. Last grade completed:

SUPPORT SYSTEM

1. Do you have a religious preference and are you active in a church now?

2. Describe the level of support and involvement of the baby's father.

3. Who will be with you for the birthing?

4. Do you anticipate having an additional support person ("doula") with you?

5. Would you like referral to available doulas in this area?

6. Who will be available to help you when you are home with this new infant?

7. Do you have friends or family available for emergency transport in case your normal transportation is not available?

8. Is there a history of abuse in either your family or your spouse's family?

LIVING ARRANGEMENTS

1. Who do you live with at this time?

2. Please describe your current housing arrangements and please let us know if you feel these arrangements will remain secure for the duration of the pregnancy and after your child is born.
3. Please list telephone numbers where you may be reached.
   Your Home Phone:
   Your Work Phone:
   Spouce's/S.O. Home Phone:

Spouce's/S.O. Work Phone:

4. Is there another number that we can contact you in the case of an emergency?

5. How will you get to your regularly scheduled appointments and do you have a preference as to the time or day of the week that those appointments would be scheduled?

ECONOMIC/FINANCIAL CONCERNS

1. What financial concerns do you have?

2. What insurance do you carry for the pregnancy?

HABITS AND ENVIRONMENTAL CONCERNS

1. Do you smoke and if so, how many cigarettes per day?

2. Have you had any alcohol since your last menstrual period?

3. Have you used any street drugs since your last menstrual period?

4. Do you use a hot tub or a sauna?

5. Are you exposed to any environmental work hazards on your job?

6. Have you had any x-rays since your last menstrual period?

7. Are you exposed to any chemicals at home or at work?

8. Any concerns about sexuality or sexual function?

NUTRITION - please list your pre-pregnant weight ________

1. Have you had any weight loss or weight gain in the last six months?

2. Do you have any food allergies?

3. Do you have any foods that you dislike and avoid?

4. How many meals per day do you eat?

5. Do you eat breakfast every day?

6. How much do you drink each day of each of the following
   Soda __________ Coffee ______________ Water ______________
   Tea ____________ Milk _______________ Juice ______________

7. How many half-cup servings of fruit do you eat per day?

8. How many half-cup servings of vegetables do you eat per day?

9. Were you taking any vitamins before the pregnancy?

10. Are you taking vitamins now?

11. Are you on any natural medications, herbs or supplements?

12. How much weight have you gained in previous pregnancies?

PLEASE CIRCLE ANY PROBLEMS LISTED BELOW THAT YOU HAVE HAD IN THE LAST YEAR: INCLUDE ANY ADDITIONAL INFORMATION YOU FEEL IS IMPORTANT:

- Fever/chills/night sweats
- Headaches/head injuries/concussion
- Eye problems (wear contacts or glasses?)
- Ear problems/hearing loss/ringing/pain
- Thyroid problems or x-ray treatment to neck or chest
- Breast masses/breast discharge/breast pain
- Breathing problems/shortness of breath/asthma/bronchitis/pneumonia/emphysema
- High blood pressure/rheumatic fever/chest pain/palpitations or skipped beats/heart murmur
- Heartbum/ulcers/gallstones/constipation/diarrhea, bloody or black bowel movements/abdominal pain
- Kidney or bladder infection/leaking urine/pain with urination/kidney stones
- Muscle pain/joint pain or swelling/broken bones/dislocations/muscle weakness
- Seizures/loss of coordination/tremors/speech problems/memory loss/numbness/tingling
- Skin changes/mole change/skin infections/hair loss/psoriasis
- Bleeding from any site/clotting problems/bruising easily/transfusions (what year?)
- Depression/poor sleeping/appetite problems/panic attacks/suicidal thoughts or attempts

GYNECOLOGIC AND OBSTETRIC HISTORY:

1. How old were you when you had your first period?
2. How often do you get your period?
3. How many days does it last?
4. Please list the first day of your last period and when did you have a positive pregnancy test?
5. Have you had any spotting or bleeding since your last menstrual period?
6. Have you had any surgery on your uterus, ovaries or cervix?
7. Have you had any abnormal pap smears?

8. When was your last pap smear?

9. Have you had any testing or treatment done for infertility?

10. Did your mother take any medication during her pregnancy with you to prevent miscarriage (for example, DES)?

11. What types of birth control have you used in the past?

PAST OBSTETRICAL HISTORY

How many pregnancies have you had?

Please list the following information for each pregnancy including any pregnancies not carried to term:

	FIRST	SECOND	THIRD	FOURTH	FIFTH	SIXTH
DATE						
SEX						
NAME						
BIRTH WEIGHT						
HOW FAR ALONG WERE YOU WHEN YOU DELIVERED?						
LENGTH OF LABOR?						
TYPE OF DELIVERY?						
COMPLICATIONS?						
PROBLEMS WITH BABY?						
DID YOU BREASTFEED?						
IF SO, HOW MANY MONTHS?						
WHAT HOSPITAL?						

MEDICATIONS AND ALLERGIES

Please list all medications that you have taken since your last menstrual period, including over-the-counter medications:

Please list any allergies or medication intolerances and the types of reactions that you have to them.

FAMILY HISTORY/GENETIC SCREENING (includes anyone in either family)

1. Are you a blood relative of the baby's father?

2. Are the following illnesses present in your families?
    - Twins
    - Down's Syndrone
    - Cystic Fibrosis
    - Thalassemia
    - Hemophilia
    - Neural Tube Defects
    - Tay-Sachs
    - Muscular Dystrophy
    - Huntington's Chorea
    - Mental Retardation
    - Other inherited Genetic Disorder
    - Patient or partner or child with birth defects not listed above

Finally, list below any questions you want to be sure to cover during your upcoming appointment.

Thank you for the time and effort it has taken for you to complete this form.

Mary E. Arenberg, M. D.
George S. Schroeder, M. D.

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TO OUR PREGNANT PATIENTS

We are happy and privileged to be providing your pregnancy care. What follows is a description of the routines of prenatal care in our office as well as answers to some of the most commonly asked questions.

SCHEDULE OF VISITS:

At each visit we will check weight gain, blood pressure, urine for signs of infection, ask questions about any symptoms of premature labor, answer any questions you have, examine the uterine size and fetal heart tones.

First OB visit (6-8 weeks - please note that this is counted from the first day of your last menstrual period; this is called your "gestational age"). We prefer to bring our patients in to formal pregnancy care as soon as the pregnancy test is positive. Starting OB care early can relieve many anxieties and some complications can be prevented. We have a lengthy questionnaire for you to complete. Please be patient! The information is very important for care of you and your pregnancy. Please complete the questionnaire and bring it with you for your first appointment - or earlier if possible.

Second OB visit (10-12 weeks). This visit is important to be able to check for the baby's heart beat "fetal heart tones".

Third OB visit (15-18 weeks). Any prenatal labs that have not been done will be drawn at this visit (see below).

Fourth OB visit (20-22 weeks). We will review all lab results. We will want to confirm the date you first were sure you felt the baby moving.

Fifth OB visit (24-26 weeks). We will test for "gestational diabetes" or pregnancy associated diabetes.

Sixth OB visit (28-30 weeks). If you are Rh negative, we will check again to see if you have become sensitive to Rh positive blood during this pregnancy. If you have not, then we will give you a injection to prevent you from becoming sensitized during the third trimester, a higher risk time.

Seventh OB visit (30-32 weeks).

Eighth OB visit (34 weeks).

Ninth OB visit (36 weeks).

Tenth through thirteenth (or more if necessary) visits are scheduled weekly from 37 weeks until delivery

During this last trimester we focus on answering any questions that you have about labor, delivery, hospital care, infant feeding and care, and birth control after this pregnancy. Fetal growth (size of the uterus) and fetal position are important during the third trimester as well as changes in maternal health - blood pressure, swelling and management of any complications of pregnancy are intensively managed through this time.

ROUTINELY RECOMMENDED PRENATAL LAB TESTS

1. Urine culture - silent urinary tract infection is common in pregnancy and increases the risk of premature labor.

2. ABO and Rh type; also a test for antibodies against other blood types.

3. Complete Blood Count - to rule out anemia.

4. Immunity against Rubella (German Measles).

5. Tests for carrier state for Hepatitis B, the AIDS/HIV virus and syphilis to decide if treatment during the pregnancy is necessary to protect both mother and fetus.

6. "AFP" or Alpha Fetoprotein test measures a protein from the fetus found in the mother's blood to determine if this pregnancy is at increased risk for having a "neural tube defect" (also called open spinal cord, spina bifida or hydrocephalus) or chromosome abnormalities of Down Syndrome or Trisorny 18. An abnormal test does not make a diagnosis; further studies would be recommended at that time. The majority of the advanced tests are normal. If a fetus is confirmed to have a problem it allows us to arrange for adequate support of your family, safest delivery route and resources needed for the infant after birth.

7. One-hour glucose tolerance test: done in high-risk mothers at 18 weeks, but more typically this is done at 24-28 weeks to test for pregnancy associated diabetes.

NON-ROUTINE PRENATAL TESTS

Ultrasound - According to the American College of Obstetrics and Gynecology there is NO indication for routine ultrasound in pregnancy. If dating for the pregnancy is unclear and fetal heartbeat is not heard when expected, then we need an US for date confirmation. If you have any complications of pregnancy we may also get an US., If you are determined to have an US and do not have a medical indication, contact your insurance company and ask about their policy and call your hospital to find out the cost of the US which will potentially be all out of pocket expense to you.

CLASSES

We strongly recommend the following for all first time parents:

1. Pregnancy and Childbirth classes.
2. Prenatal exercise class.
3. Breastfeeding class - even if you haven't made up your mind about breastfeeding.
4. Parents as Teachers or "P. A. T." through the Family Resource Center.
5. Infant CPR.

In addition, for our patients on Healthy Start or Medical Assistance, we make referrals to "Prenatal Care Coordination" to make sure all possible resources are made available for a healthy pregnancy.

COST OF CARE AND INSURANCE

We request that all our pregnant patients discuss this directly with Judy Klein in our front office. This will be scheduled with one of your prenatal visits.

EMERGENCY NEEDS

During office hours (Monday and Tuesday 8 a.m. - 6 p.m., Wednesday - Friday 8 a.m. 5 p.m., Saturday 9 a.m. - 12 noon) please call here with any urgent concerns (see warning signs below). Office number is 893-0526.

During all non-office hours: Our home number: 920-893-5757. If no answer call the hospital OB unit where you plan to deliver and they will reach us by pager.

REASONS TO CONTACT US:

1 . Severe headache that does not subside with Tylenol in 2 - 3 hours.
2. Burning or painful urination.
3. Fever above 102 degrees.
6. Blurred vision.
7. Any bleeding.
8. Any vaginal leaking of watery fluid.
9. Severe nausea and vomiting.
10. Severe lower abdominal pain that does not subside.
11. Sudden facial swelling.
12. Concerns about fetal movement.

"COVERAGE"

Drs. Arenberg and Schroeder make it a priority to be available to our patients if at all possible. We are married (since 1983) and have two children and do take family time off. In addition, we are required to obtain a minimum of 300 hours of continuing medical education every six year period (along with completing our Board exam every six years) to maintain our Family Practice certification and that will also cause us to be unavailable at times. Please understand that we intend, if at all possible, to be with you when you need us; but when this is not possible our cross coverage is with the family physicians at the Sheboygan Clinic - Plymouth (Drs. Sharon, Poulette, and Gavin) if you deliver at Sheboygan Memorial Medical Center, or the physicians at Marsho Medical if you deliver at St. Nicholas Hospital.

HOSPITAL Dr.. Arenberg delivers babies at both St. Nicholas Hospital and Sheboygan Memorial Medical Center.

Please bring your questions and concerns to each visit. Please bring your binder with you as well (this will be given to you at your first visit).

Dr. Mary E. Arenberg, M. D.
Dr. George S. Schroeder, M. D.

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