

PATIENT REGISTRATION FORM

NAME: _____ DOB: _____

SS#: _____

ADDRESS: _____

HOME#: _____ CELL#: _____

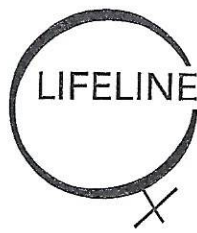
E-MAIL ADDRESS: _____

INSURANCE NAME: _____

EMPLOYER NAME: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ PHONE#: _____



LIFELINE MEDICAL ASSOCIATES, LLC

WOMEN'S HEALTHCARE IS OUR LIFE'S WORK

Consent for Screening Test During Pregnancy

- **Sequential Screening** is a way to estimate the chance that a baby will be born with Down syndrome, trisomy 18, or an open neural tube defect such as spina bifida. It combines measurements from two blood tests and a first trimester ultrasound, along with other details about you, to give you a more specific risk.

ACCEPT : _____ DECLINE: _____ INT: _____

- **ClariTest from GenPath (Bio-Reference):** The Right Choice for Non-Invasive Prenatal Testing
ClariTest™ from GenPath harnesses the power of massively parallel sequencing to screen for fetal chromosomal abnormalities. ClariTest is a safe, non-invasive prenatal test (NIPT), performed as early as 10 weeks of gestation from a simple blood draw, exhibiting outstanding sensitivity and specificity for the most common trisomies and specific microdeletion syndromes.

ACCEPT : _____ DECLINE: _____ INT: _____

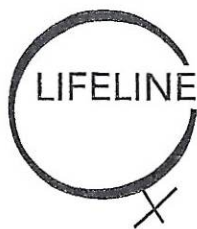
- **In-Herigen Carrier screening** for inherited genetic conditions is an important part of preconception and prenatal care. Historically, genetic carrier screening only covered single genes for specific ethnicities. According to the Census Bureau, by the year 2043 the majority of the U.S. population will be so ethnically diverse that no single group will make up a majority. InheriGen performs carrier testing for multiple conditions at once, at significantly lower cost than running each of these tests separately. The InheriGen Panel is comprised of over 180 inherited diseases and more than 720 mutations tested from a single blood or oral rinse sample. These autosomal recessive and X-linked disorders are associated with childhood onset conditions, many of which are either lethal or have severe symptoms.

ACCEPT : _____ DECLINE: _____ INT: _____

Comprehensive Women's Care Of Paramus

2 Sears Drive, Suite 104, Paramus, NJ 07652 (201) 262-0075 Fax: (201) 262-9440

www.LMA-LLC.com



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In-Herigen includes 3 major screens which is important to know during your pregnancy.

Cystic fibrosis is an inherited disease in which mucus glands produce abnormal secretions. Normally mucus is slippery and lubricates and protects the lining of various organs and tissues. People with cystic fibrosis have mucus which is thick and sticky, which can obstruct and interfere with normal bodily function. This results in tissue and organ damage, most typically in the lungs and digestive tract. Unfortunately, cystic fibrosis is a lifelong disease which usually results in a shortened life expectancy.

ACCEPT : _____ DECLINE: _____ INT: _____

Spinal muscular atrophy is a neurodegenerative disease that causes the misfiring of neurons in the spine from the lack of an essential protein. This leads to atrophy (wasting away) of the skeletal muscles as well as overall weakness,

ACCEPT : _____ DECLINE: _____ INT: _____

Tay-Sachs disease measures the amount of an enzyme called hexosaminidase A (hex A) in the blood. ... **Tay-Sachs** is an inherited **disease** in which the body can't break down fatty substances as it should, so the fatty substances collect in the nerve cells of the brain and damage them.

ACCEPT : _____ DECLINE: _____ INT: _____

Patient Signature: _____ Date: _____

Provider/Witness: _____

ANTEPARTUM RECORD

DATE _____

NAME _____
LAST FIRST MIDDLE

ID# _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP Dr Craig Wiener

BIRTHDATE		AGE	RACE	MARITAL STATUS	ADDRESS	
OCCUPATION		S M W D SEP EDUCATION (LAST GRADE COMPLETED)		ZIP	PHONE	(H) (O)
<input type="checkbox"/> HOMEMAKER <input type="checkbox"/> OUTSIDE WORK <input type="checkbox"/> STUDENT		Type of Work		INSURANCE CARRIER/MEDICAID#		
HUSBAND/FATHER OF BABY		PHONE		EMERGENCY CONTACT PHONE		
TOTAL PREG	FULLTERM	PREMATURE	AB.INDUCED	AB.SPONTANEOUS	MULTIPLE BIRTHS	ECTOPICS
LIVING						

MENSTRUAL HISTORY

LM ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENES MONTHLY ☐ YES ☐ NO FREQUENCY: Q _____ DAYS MENARCH _____ (AGE ONSET)

☐ UNKNOWN ☐ NORMAL AMOUNT / DURATION PRIOR MENES _____ DATE ONBCPATCONCEPT. ☐ YES ☐ NO hCG+ _____ / _____ / _____

☐ FINAL _____

PAST PREGNANCIES (LAST SIX)									
DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

PAST MEDICAL HISTORY							
	ONeg +Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT			ONeg +Pos	DETAIL, POSITIVE REMARKS INCLUDE DATE & TREATMENT	
1.DIABETES			16.D(Rh) SENSITIZED				
2.HYPERTENSION			17.PULMONARY (TB,ASTHMA)				
3.HEART DISEASE			18.ALLERGIES (DRUGS)				
4.AUTO IMMUNE DISORDER			19.BREAST				
5.KIDNEY DISEASE/UTI			20.GYN SURGERY				
6.NEUROLOGIC/EPILEPSY			21.OPERATION/HOSPITALIZATIONS (YEAR & REASON)				
7.PSYCHIATRIC							
8.HEPATITIS/LIVER DISEASE							
9.VARICOSITIES/PHLEBITIS			22.ANESTHETIC COMPLICATIONS				
10.THYROID DYSFUNCTION			23.HISTORY OF ABNORMAL PAP				
11.TRAUMA/DOMESTIC VIOLENCE							
12.HISTORY OF BLOOD TRANSFS							
	AMT/DAY PRE-PREG	AMT/DAY PRE-PREG	#YEARS USE	24.UTERINE ANOMALY / DES			
13.TOBACCO				25.INFERTILITY			
14.ALCOHOL				26.RELEVANT FAMILY HISTORY			
15.STREET DRUGS				27.OTHER			

COMMENTS: _____

SYMPTOMS SINCE LMP

	YES	NO		YES	NO
1. PATIENT'S AGE (35 OR OLDER)	<input type="checkbox"/>	<input type="checkbox"/>	12. MENTAL RETARDATION / AUTISM	<input type="checkbox"/>	<input type="checkbox"/>
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND) MCV < 80	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, WAS PERSON TREATED FOR FRAGILEX?	<input type="checkbox"/>	<input type="checkbox"/>
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)	<input type="checkbox"/>	<input type="checkbox"/>	13. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
4. CONGENITAL HEART DEFECT	<input type="checkbox"/>	<input type="checkbox"/>	14. MATERNAL METABOLIC DISORDER (EG. INSULIN DEPENDENT DIABETES, PKU)	<input type="checkbox"/>	<input type="checkbox"/>
5. DOWN SYNDROME	<input type="checkbox"/>	<input type="checkbox"/>	15. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE	<input type="checkbox"/>	<input type="checkbox"/>
6. TAY-SACHS (EG. JEWISH, CAJUN, FRENCH-CANADIAN)	<input type="checkbox"/>	<input type="checkbox"/>	16. RECURRENT PREGNANCY LOSS, OR A STILL BIRTH	<input type="checkbox"/>	<input type="checkbox"/>
7. SICKLE CELL DISEASE OR TRAIT (AFRICAN)	<input type="checkbox"/>	<input type="checkbox"/>	17. MEDICATIONS / STREET DRUGS / ALCOHOL SINCE LAST MENSTRUAL PERIOD	<input type="checkbox"/>	<input type="checkbox"/>
8. HEMOPHILIA	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, AGENT(S)	<input type="checkbox"/>	<input type="checkbox"/>
9. MUSCULAR DYSTROPHY	<input type="checkbox"/>	<input type="checkbox"/>	18. ANY OTHER	<input type="checkbox"/>	<input type="checkbox"/>
10. CYSTIC FIBROSIS	<input type="checkbox"/>	<input type="checkbox"/>			
11. HUNTINGTON CHOREA	<input type="checkbox"/>	<input type="checkbox"/>			

COMMENTS / COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1. HIGH RISK HEPATITIS B / IMMUNIZED?	<input type="checkbox"/>	<input type="checkbox"/>	4. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD	<input type="checkbox"/>	<input type="checkbox"/>
2. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB	<input type="checkbox"/>	<input type="checkbox"/>	5. HISTORY OF STD, GC, CHLAMYDIA, HPV, SYPHILIS	<input type="checkbox"/>	<input type="checkbox"/>
3. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES	<input type="checkbox"/>	<input type="checkbox"/>	6. OTHER (SEE COMMENTS)	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS _____

INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION

DATE	PRE-PREGNANCY WEIGHT	HEIGHT	BP
1. HEENT	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	12. VULVA	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
2. FUNDI	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	13. VAGINA	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
3. TEETH	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	14. CERVIX	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
4. THYROID	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	15. UTERUS SIZE	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
5. BREASTS	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	16. ADNEXA	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
6. LUNGS	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	17. RECTUM	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
7. HEART	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	18. DIAGONAL CONJUGATE	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
8. ABDOMEN	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	19. SPINES	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
9. EXTREMITIES	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	20. SACRUM	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
10. SKIN	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	21. SUBPUBIC ARCH	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>
11. LYMPH NODE	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>	22. GYNECOD PELVIC TYPE	NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/>

COMMENTS (Number and explain abnormalities) _____

EXAMINED BY _____