MATERNAL FETAL CARE, P.C.

PATIENT INTAKE PART 1
Patient Demographics

Please print or type all requested information and sign where indicated.

Last Name _____ **First Name** _____ **Middle Initial** _____
Date of Birth ____ / ____ / ____ **Occupation** _____ **Marital Status: S M W D**
Highest Education Level: ☐ High School ☐ Assoc/Bachelor's ☐ Master's ☐ Doctorate
Home Address _____

Street (and Apt # if Applicable)

_____

City ***State*** ***Zip Code***

Cell Phone _____ **Other Phone (Circle: Home/Work)** _____
Email _____

___ [Initials] ***I consent to have sensitive medical information left on my voicemail and sent to my email.***

Based on government guidelines we are required to ask you race, ethnicity, and preferred language. This information will be used to help monitor quality and improve patient care.

Mark all that apply for the Parental/Donor ethnic backgrounds
(*M = maternal/egg donor P = paternal/sperm donor*).

Ethnic Origin	***M/P***	***Ethnic Origin***	***M/P***
Ashkenazi Jewish		Asian, Pacific Islander	
Sephardic Jewish		Asian Indian	
French Canadian		Middle Eastern	
White, European		Hispanic	
African American, African, Black		Native American	
Other:		Other:	

Primary Language ☐ English ☐ Spanish ☐ Creole ☐ Other _____

Sex ☐ assigned female at birth ☐ assigned male at birth ☐ intersex ☐ other: _____

Gender ☐ female ☐ male ☐ trans man ☐ trans woman ☐ genderqueer ☐ questioning ☐ other: _____

Sexual Orientation ☐ straight ☐ lesbian/gay ☐ bi/pan ☐ queer ☐ poly ☐ question ☐ asexual ☐ other:__

Pronouns **(***Please circle all that apply)* She/Her He/Him They/Them Other:_____

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Partner/Father of the Baby's (FOB) Name: _____

Phone: _____ Email: _____ Occupation: _____

Pronouns **(***Please circle all that apply)* She/Her He/Him They/Them Other:_____

Address ☐ Same as mine ☐ Different as mine, fill out below

_____

Street (and Apt # if Applicable)

_____

City ***State*** ***Zip Code***

Emergency Contact ☐ Same as Partner/FOB ☐ Different, fill out below

Name _____ Phone _____

Relationship to patient _____

Advanced Directives

Will you accept blood products in a live-saving emergency? ☐ No ☐ Yes

Do you have an advanced directive or living will? ☐ No ☐ Yes

Do you have a durable power of attorney? ☐ No ☐ Yes _____

Do you have a do not resuscitate document? ☐ No ☐ Yes

Please list all your other healthcare providers below. Please request an additional form if you have more than five providers.

Provider's Full Name	*Specialty*	*Address and/or Phone Number*
	Referring Doc	
	Primary Doc	

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Insurance Information

Primary Insurance Information

Insurance Company Name _____

ID _____ Group # _____

Subscriber _____ DOB _____ Employer of Subscriber _____

Relationship to you _____

Secondary Insurance Information

Insurance Company Name _____

ID _____ Group # _____

Subscriber _____ DOB _____ Employer of Subscriber _____

Partner Insurance Information

□ Partner/FOB has the same insurance □ Partner/FOB has different insurance, provide below

Insurance Company Name _____

ID _____ Group # _____

Subscriber _____ DOB _____ Employer of Subscriber _____

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. Genetic screening/testing are billed by the genetic laboratory and not by our office.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to Maternal Fetal Care, PC for medical services rendered to me and/or my dependants regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorize Release of Information

I hereby authorize Maternal Fetal Care, PC to (1) release any information necessary to insurance carriers regarding my care and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Maternal Fetal Care, PC on behalf of myself and/or my dependants, and understand that by making this request, I become fully financially responsible for any and all changes incurred in the course of treatment authorized.

Maternal Fetal Care, PC reserves the right to terminate the Practice-Patient relationship under certain circumstances including, but not limited to, patient misconduct and recurrent no-shows pursuant to our practice policy.
I further understand that cost shares are assigned by my insurance carrier are due and payable at the time of services unless prior arrangements have been made.

Patient/Responsible Party Signature _____ Date _____

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Authorization to Disclose Information to Third Parties

You are <u>not</u> required to sign this Optional Authorization; however, if you would like us to communicate with your partner, father of the baby, family member, friend, or other third party about your care, we require its completion.

To assist in my evaluation or administration of my care, I authorize Maternal Fetal Care, PC, its subsidiaries, and its duly authorized representatives to share personal health and financial information relating to my care with the family members, friends, and/or other third parties listed below:

Partner/FOB_____ Phone _____

Other family member _____ Phone _____

Other family member _____ Phone _____

Other person _____ Phone _____

Other person _____ Phone _____

___ [Initials] ***I do <u>not</u> give permission to Maternal Fetal Care, PC to discuss my medical care with other parties.***

I understand that such information about my care may include information related to any disorder of the immune system including, but not limited to, HIV, AIDS; use of drugs and alcohol; and mental and physical history, condition, advice, or treatment, but does not include psychotherapy notes.

I do <u>not</u> wish for the following information about my care to be shared: (*leave blank if not applicable*)
_____

I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy or health information.

I may revoke this authorization in writing at any time except to the extent that Maternal Fetal Care, PC or the authorized recipient of my information has relied on it prior to receiving my notice of revocation. I may revoke this authorization by sending written notice to ***1275 Summer Street Suite 306, Stamford, CT 06905***.

This authorization is valid for the shorter of five (5) years or the duration of my care. I may request a copy of the authorization and a copy should be valid as the original.

Patient signature _____ Date _____

Printed Name _____

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Health Information Portability and Accountability Act (HIPPA)
Patient Acknowledgement of Notice of Practices

I hereby acknowledge that a copy of Maternal Fetal Care, PC's
Notice of Privacy Practices has been made available to me.
You can request it from Kira Dineen (kdineen@matneralfetalcarepc.com)

Name _____

Signature _____

Date _____

Relationship to patient (*if not patient*): _____

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

MATERNAL FETAL CARE, PC FINANCIAL POLICY

Our goal is to provide and maintain an open physician-patient relationship. Informing you of our office policies in advance allows for a good flow of communication. Please read this carefully. If you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please let the front desk know you are here and sign in. It is your responsibility to notify the office of any new insurance coverage, address changes or other changes in demographic information.

2. We require that all patients maintain a valid credit card on file with us. Any patient balances that are present after 30 days will be automatically billed to your credit card. If your credit card is not valid, any balance over 60 days will be forwarded to a collection agency, unless other payment plans have been previously arranged.

3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill**.**

4. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you.

5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.

6. If our providers do not participate in your insurance plan, or you have no insurance, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit. If you are experiencing financial hardship, please communicate with our office staff. We would be happy to set you up on an automatic payment plan.

7. We require advance notice for canceling appointments. There is a **$25** automatic charge for missed appointments during pregnancy if not canceled two hours prior. There is a **$50** charge for missed gynecology appointments if not canceled 24 hours prior.

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

MATERNAL FETAL CARE, PC FINANCIAL POLICY (*continued)*

8. A **$25** fee (*plus any bank fees incurred*) will be charged for any checks returned for insufficient funds.

9. We provide services such as pessary device ($100), TDaP vaccination ($100), Rhogam injections ($150) that are not typically covered by your insurance company. The fee for each of these services will be the patient's responsibility, due at time of service.

10. Our office provides medical records free of charge, up to 25 pages. After 25 pages, you will be charged $0.35 a page. A records release form must be completed for each request.

11. Before making an annual gynecology appointment, it is your responsibility to check with your insurance company regarding whether the visit will be covered as an annual visit. Not all plans cover annual physicals for routine screening. If it is not covered, you will be responsible for payment at the time of visit.

12. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

13. If you have any questions, please feel free to contact our business manager, Samantha Howell showell@maternalfetalcarepc.com.

I have read and understand the office financial policy and agree to comply with and accept responsibility for any payment that becomes due as outlined.

****This signature will serve as credit card authorization signature for remaining balances*.

X _____

Date:_____

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

PATIENT INTAKE PART 2
Patient Clinical Intake

Current Pregnancy

Current Weight _____ lbs Pre-Pregnancy Weight _____ lbs Height _____ feet _____ inches
First day of your last menstrual period _____ ☐ certain ☐ estimated ☐ unsure

Estimated due date _____ based upon ☐ last menstrual period ☐ ultrasound

Number of fetuses: Singleton / Twins / Triplets / Quadruplets

Conception: ☐ Naturally Conceived/Spontaneous ☐ IUI ☐ IVF ☐ fertility medications

If you used reproductive technology…

IUI date _____ Embryo Transfer date _____

With *my own* egg: Fresh cycle / Frozen cycle Your age at egg retrieval _____

With *a donor* egg: Fresh cycle / Frozen cycle Their age at egg retrieval _____

Stage at embryo transfer, circle: *Cleavage stage* *Blastocyst stage (day 5/6)*

Number of embryos transferred _____

Genetic Screenings performed

☐ PGT-**A**neuploidy ☐ PGT-**M**onogenetic (*single gene*) ☐ PGT-**SR** *(structural chromosomal rearrangement)*

☐ Carrier Screening *(Counsyl/Myriad/Foresight, Natera/Horizon, SEMA4, JScreen/ReproGEN)*

☐ NIPS *(non-invasive prenatal screening; Myriad/Counsyl/Prequel, Natera/Panorama, MaterniT21)*

☐ Parental Karyotype/Chromosomes *(Ex: 46,XX, 46,XY, etc.)*

☐ Level II Anatomy Scan ~20 weeks

☐ Other:_____

Invasive testing performed

☐ CVS (*chorionic villus sampling*) date _____ result _____

☐ Amniocentesis date _____ result _____

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Past Obstetrical History

☐ *I have never been pregnant*

Total # of Pregnancies *(include current)*	# of Full-Term Births *(>37wks)*	# of Premature Births *(<37wks)*	# of Abortions 1st trimester	# of Abortions 2nd trimester	# of Miscarriages 1st trimester	# of Miscarriages 2nd trimester	# of Multiple Births *(Twins/ Triplets)*	# of Ectopics	# of Living Children

Are you currently taking care of any children that are not your biological children ? ☐ Yes ☐ No

(# should equal total number of pregnancies listed above, including present)

#	Date	Place of Delivery	Outcome *Live Birth, Stillbirth, Miscarriage, Termination, or Ectopic*	Gestational Age *Weeks Pregnant at delivery; Ex: 39 wks*	Birth Weight	Assigned Sex at Birth *(Female, Male, Etc.)*	Delivery *vaginal, forceps, c-section, vacuum, VBAC, D&C, D&E*	Comments/ Complications/ Hours in Labor/ Epidural
1								
2								
3								
4								
5								
6								
7								
8								
9								

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Gynecological History

Are your periods regular? ☐ Yes ☐ No If not, please describe your pattern _____

How many days does your period last? _____ How many days between cycles? _____

Age at first period _____ Circle any symptoms: ☐ Cramps ☐ Passing Clots ☐ Heavy Bleeding

When was your last pap smear? _____ Have you had an abnormal pap smear? ☐ Yes ☐ No

Have you ever had a… ☐ LEEP ☐ Cryotherapy ☐ Cone Biopsy

Have you been diagnosed with…. ☐ Uterine Fibroids ☐ Ovarian Cysts ☐ Endometriosis ☐ PCOS

Do you have a history of infertility? ☐ Yes ☐ No If yes, for how long _____

When was your last mammogram? _____ Do you perform self breast exams? ☐ Yes ☐ No

☐ I or my family has a *BRCA* variant/mutation Do you have benign breast disease? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No If yes, are you currently satisfied with your sexuality and sexual practices? ☐ Yes ☐ No

Present method of birth control? ☐ Birth Control Pills ☐ IUD ☐ Diaphragm ☐ Condoms ☐ None/NA

Number of lifetime sexual partners? _____

Do you have any history of trauma or assault that may affect your experience talking about or having a physical exam performed? ☐ Yes ☐ No

Have you ever been treated for the following? *Circle any that apply,* and indicate date: _____

Vaginosis Genital warts (HPV) Chlamydia Herpes Trichomonas Gonorrhea Syphilis

Have you ever been tested for HIV? ☐ Yes ☐ No **Result:** ☐ Positive ☐ Negative *Date of test* _____

Have you received the HPV vaccine (Gardasil)? ☐ Yes ☐ No

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Past Medical History

Condition	Year	Comments
Anemia/Blood Transfusions		
Anesthetic complications		
Arthritis/Joint pain		
Asthma		
Autoimmune disorder		
Birth Defects/Genetic Conditions		
Bladder Disease		
Blood clots/ PE/ Thrombophilia		
Blood transfusions		
Cancer		
Chronic Lung Disease		
Depression/Postpartum		
Dermatologic disorder		
Diabetes (type 1 or type 2)		
Endocrine Disorders		
Fracture		
Gastrointestinal Problems		
Gestational Diabetes		
Glaucoma		
Headaches/Migraines		
Heart Problems/Murmur		
Hepatitis/Liver Disease		
High Blood Pressure		
Hyperlipidemia		
Infertility		
Kidney Disease/Stones		
Multiple Sclerosis		
Neurological disorder		
Osteoporosis		
Pneumonia		
Psychiatric illness		
Rheumatic Fever		
Seizures/Epilepsy		
Sexually Transmitted Infections		
Stroke		
Thyroid Disease		
Trauma/Violence		
Tuberculosis		
Ulcers		
Varicosities/Phlebitis		

COVID-19 History

Ever been diagnosed with COVID-19?
☐ No ☐ Yes; date of onset: _____

If yes, were you hospitalized? ☐ No ☐ Yes

☐ Asymptomatic ☐ Symptomatic
☐ Shortness of Breath ☐ Cough
☐ Fever/Chills ☐ Muscle aches
☐ Headaches ☐ Sore Throat
☐ Loss Taste/Smell ☐ Nausea/Vomiting
☐ Congestion ☐ Diarrhea

☐ Not vaccinated
☐ Vaccinated ☐ Pfizer ☐ Moderna ☐ J&J
☐ Original 2 Doses ☐ Boosted

Surgery and Hospitalizations History

☐ Never had surgery or been hospitalized

Date	Hospital	Procedure	Reason

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Current Medications

(Include vitamins, PNV, and herbal supplements)

☐ **I am not taking any medications**.

	Medication Name	Dosage & Frequency	Indication for Medication	Prescribing Provider
1				
2				
4				
5				
6				
7				
8				

Allergies

☐ *I do not have any allergies* *(Include all medication, environmental & food allergies)*

Allergen	Symptoms

Preferred Pharmacy

Do we have your consent to obtain your medication history from your pharmacy/pharmacist? ☐ *Yes* ☐ *No*

Name	Address	City	State	Zip Code	Telephone	Mail Order or Retail

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Social History

Alcohol/Smoking/Drug Use

Do you smoke/use tobacco? ☐ Yes (currently / previously) # of packs per day _____ x _____ # of years

☐ No *(not currently /not ever)* Do you vape? ☐ Yes ☐ No *(not currently /not ever)*

Are you exposed to 2nd hand smoke at home or work? _____

How much caffeine do you consume? # of ounces/day _____ Type _____

How much alcohol do you consume? # of drinks/week _____ Type _____

What recreational drugs do you use/have you used? ☐ None ☐ Hookah ☐ Marijuana ☐ Cocaine

☐ Crack ☐ Oxycontin/Opioids ☐ Fentanyl ☐ Heroin ☐ LSD ☐ Whippets ☐ PCP ☐ MDMA

Method of drug use? ☐ Smoking ☐ Snorted ☐ Injected ☐ Swallowed

Do you have any exposure to any of the substances above during your current pregnancy? ☐ Yes ☐ No

Lifestyle Habits

How often do you exercise per week? _____ Type of exercise _____
List any dietary restrictions _____ ☐ Vegetarian / Vegan ☐ Gluten-free

Wear a seatbelt? ☐ Always ☐ Sometimes ☐ No International travel in last year? ☐ No ☐ Yes; Location_____

Psychosocial History

**Please disregard questions if you are not currently pregnant.*

Was this a planned pregnancy? ☐ Yes ☐ No Is this a desired pregnancy? ☐ Yes ☐ No

How do you feel about being pregnant?

Very Poor ← *1* *2* *3* *4* *5* → *Very good*

Any psych difficulties with previous pregnancies/births? *(Ex: postpartum depression)* ☐ Yes ☐ No

How is your mood this pregnancy?

Very Poor ← *1* *2* *3* *4* *5* → *Very good*

Are you experiencing any unusual stress? ☐ Yes ☐ No If yes, would you like to talk? ☐ Yes ☐ No

Have you experienced significant anxiety, depression, psychological/emotional issues? ☐ Yes ☐ No

Have you ever seen a therapist, psychologist, or psychiatrist? ☐ Yes, Current ☐ Yes, Past ☐ No

Have you ever or are you currently taking any mental health medications? ☐ Yes ☐ No

Have you ever attempted or considered suicide? ☐ Yes ☐ No

Have you ever been hospitalized for any mental health or emotional condition? ☐ Yes ☐ No

Have anyone in your family had a problem with the abuse of drugs or alcohol? ☐ Yes ☐ No

Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No

Have you ever experienced domestic violence? ☐ Yes ☐ No Do you feel safe at home? ☐ Yes ☐ No

If you have a partner, how is your relationship? ☐ N/A

Very Poor ← *1* *2* *3* *4* *5* → *Very good*

Are family/friends supportive about your pregnancy? Are they a support network? ☐ Yes ☐ No

Are you working? ☐ Yes ☐ No If yes, will you take maternity leave? ☐ Yes for ____ months ☐ No

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Biological Family Health History

	Maternal/Egg Donor	*Paternal/Sperm Donor*	*Affected Relative*
Consanguinity *(Related to partner, like cousins)*			☐ Yes
Cystic Fibrosis	☐	☐	_____
Muscular Dystrophy	☐	☐	_____
Genetic metabolic disorders *(PKD)*	☐	☐	_____
Down syndrome	☐	☐	_____
Other chromosome abnormalities	☐	☐	_____
Fragile X Syndrome	☐	☐	_____
Huntington's Disease	☐	☐	_____
Blood Disorders *(Sickle Cell Disease, Hemophilia)*	☐	☐	_____
Blood Clots	☐	☐	_____
High Blood Pressure	☐	☐	_____
Blindness	☐	☐	_____
Deafness	☐	☐	_____
Anencephaly (*incomplete formation of the skull*)	☐	☐	_____
Spina bifida (*opening in the spine*)	☐	☐	_____
Cleft lip/palate	☐	☐	_____
Clubfoot	☐	☐	_____
Heart defect	☐	☐	_____
Hydrocephalus	☐	☐	_____
Extra fingers or toes	☐	☐	_____
Other birth defects	☐	☐	_____
Intellectual disabilities	☐	☐	_____
Multiple Miscarriages	☐	☐	_____
Stillbirth	☐	☐	_____
Infant death *(SIDS)*	☐	☐	_____
Mental Health Issues *(Bipolar, Schizophrenia)*	☐	☐	_____
Autism	☐	☐	_____
Seizures	☐	☐	_____
Infertility	☐	☐	_____
Kids using wheelchairs/crutches	☐	☐	_____
Stroke	☐	☐	_____
Diabetes (Type 1 or 2)	☐	☐	_____
High Cholesterol	☐	☐	_____
Heart Disease	☐	☐	_____
Breast Cancer	☐	☐	_____
Colon Cancer	☐	☐	_____
Ovarian Cancer	☐	☐	_____
Prostate Cancer	☐	☐	_____
Other Cancer	☐	☐	_____
Other	☐	☐	_____
***NONE of the above apply*	☐	☐	

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com

Review of Systems

(Check any symptoms you are currently experiencing.)

Constitutional	☐ Negative ☐ Fever	☐ Weight loss ☐ Fatigue	☐ Weight Gain ☐ Other
Eyes	☐ Negative ☐ Other	☐ Vision Change	☐ Glasses or Contacts
Ears, Nose, Throat	☐ Negative ☐ Headache	☐ Ulcers ☐ Hearing Loss	☐ Sinus Trouble ☐ Other
Cardiovascular	☐ Negative ☐ Swelling	☐ Palpitations ☐ Chest Pain	☐ SOB on exertion ☐ Other
Respiratory	☐ Negative ☐ Wheezing	☐ Bloody mucus ☐ Cough	☐ Shortness of Breath ☐ Other
Gastrointestinal	☐ Negative ☐ Fecal Incontinence ☐ Indigestion ☐ Other	☐ Flatulence ☐ Constipation ☐ Diarrhea	☐ Nausea/Vomiting ☐ Bloody Stool ☐ Pain
Urinary	☐ Negative ☐ Frequency ☐ Burning with urination	☐ Blood In urine ☐ Incomplete Emptying ☐ Other	☐ Incontinence ☐ Urgency
Gynecological	☐ Negative ☐ Painful periods ☐ Other	☐ Abnormal Bleeding ☐ Painful intercourse	☐ Vaginal discharge ☐ PMS
Musculoskeletal	☐ Negative ☐ Other	☐ Muscle Weakness	☐ Muscle or joint pain
Skin	☐ Negative ☐ Dry skin	☐ Rash ☐ Ulcers	☐ Pigmented lesions ☐ Other
Breast	☐ Negative ☐ Nipple Discharge	☐ Breast pain ☐ Other	☐ Breast lump
Neurologic	☐ Negative ☐ Trouble walking ☐ Other	☐ Fainting ☐ Memory Problems	☐ Numbness ☐ Seizures
Psychiatric	☐ Negative ☐ Anxiety	☐ Depression ☐ Other	☐ Crying
Endocrine	☐ Negative ☐ Hot flashes ☐ Heat/Cold Intolerance	☐ Diabetes ☐ Hair loss ☐ Other	☐ Hypothyroid ☐ Hyperthyroid
Hematological/Lymphatic	☐ Negative ☐ Swollen Lymph nodes	☐ Bruising ☐ Other	☐ Bleeding
Comments/Reviewed:			

Maternal Fetal Care, P.C.
1275 Summer Street, Suite 306, Stamford, CT 06905
(T) 203-978-5775 (F) 203-978-5777
maternalfetalcarepc.com