

Maternal-Fetal Medicine

At Associates in Women's Health, P.A.

Appointment Information:

Desired Appointment Type: (Check all that apply)

- Consultation with Ultrasound Consultation Only Fetal Non-Stress Test BPP
 Nuchal Translucency Routine Ultrasound Only Amniocentesis

Timeframe: _____

Special Appointment Needs: _____

Demographic Information:

Patient Name: _____ DOB: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Home: _____ Cell: _____ Work: _____ Other Ph: _____

Best time to call: _____ Preferred Number to call: _____

EDC: _____ Gravida: _____ Para: _____

DX: _____

Referring Physician: _____ Phone: _____ Fax: _____

Contact Name: _____ Phone: _____

Insurance Information:

 (Please complete all below, or attach a copy of the patient's insurance card.)

Insurance Company: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Policyholder: _____ Policyholder's DOB: _____

Policy Number: _____ Group Number: _____

Patient Medical Records Needed:

All current pregnancy prenatal records including:

- Labs Previous pregnancy records (if pertinent)
 Ultrasounds

Maternal-Fetal Medicine Forms Supplied:

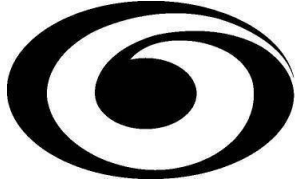
 (Check all that apply)

- Appointment Sheet with map Introduction to Maternal-Fetal Medicine Letter
 Health History Form

Thank you for your referral. Once we receive this completed form, we will contact your patient for an appointment with Maternal-Fetal Medicine. We will also send you a fax with your patient's appointment date and time.

Darren M. Farley, M.D., F.A.C.O.G.

3232 East Murdock, 2nd Floor Wichita, KS 67208 P – (316) 239-2850 F – (316) 239-2852



Maternal-Fetal Medicine

At Associates in Women's Health, P.A.

Dear Patient and Family,

Welcome to Associates in Women's Health, P.A. Dr. Darren Farley is a board certified, Obstetrician/Gynecologist who has completed his fellowship in Maternal-Fetal Medicine. The ultrasonographers working with Dr. Farley each have more than 20 years of ultrasound experience, and each have 10-15+ years, of experience working with maternal-fetal patients.

Maternal-Fetal Medicine, also referred to as perinatology, is the study and care of **Complicated and High Risk Pregnancies**. We see and treat patients for a wide variety of reasons. Some include:

- Maternal conditions:
 - Diabetes
 - High blood pressure
 - Lupus
- Fetal Conditions:
 - Abnormal pregnancy screening results
 - Abnormal ultrasound findings
- Twins, triplets or more
- Amniocentesis
- Family history of abnormalities, including genetic abnormalities
- Pre-pregnancy counseling

Your personal physician will continue with your pregnancy care and the delivery of your baby. If you do not have an Obstetrician or Family Physician in the Wichita area and need to deliver your baby here, Dr. Farley will arrange for an Obstetrician to assume your care here in Wichita.

At your first visit, Dr. Farley and his staff will perform a detailed review of your past and present medical history. Depending on the reason for your visit, you may receive an ultrasound and/or other fetal testing. Some of the testing will be determined by the findings of this visit. You should plan to spend about two (2) hours here at your first visit. All results that are available will be discussed with you at that time. Dr. Farley will also discuss those results and a plan of care, if indicated, with your personal physician. It is not unusual for you to see Dr. Farley for only one visit, however, at anytime your doctor may refer you for another appointment, ultrasound or other testing.

Most likely, you and your family will have questions. Please feel free to write them down and bring them with you. Our goal is to keep you completely informed and educated about the circumstances surrounding your visit with us.

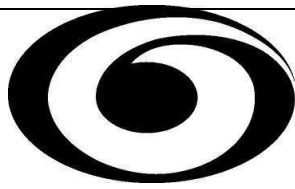
We are looking forward to assisting you and your doctor during this pregnancy. If you have questions regarding your up-coming visit, please call and talk with one of our staff. The telephone number is 316-239-2850.

Sincerely,

Associates in Women's Health, P.A.

Darren M. Farley, M.D., F.A.C.O.G.

3232 East Murdock, 2nd Floor Wichita, KS 67208 P – (316) 239-2850 F – (316) 239-2852



Maternal-Fetal Medicine

At Associates in Women's Health, P.A.

Welcome to Maternal-Fetal Medicine,

Your personal physician has requested a comprehensive evaluation of you and your unborn baby. This evaluation may consist of any one or more of the following: detailed pregnancy ultrasound, maternal-fetal consultation and antenatal fetal testing.

You and your baby deserve our mutual undivided attention, so we respectfully request that your appointment be an **ADULT ONLY** visit. You should plan to be in our office as long as 2 hours, although your individual appointment needs will dictate the length of your visit.

You are welcome to bring 2 or 3 additional adults to be with you during your appointment. Any children accompanying you will need adult supervision while remaining in the waiting room for the duration of your appointment or in the event any procedures, such as amniocentesis, are necessary. If you are unable to obtain adult supervision for your children, you will be asked to reschedule your appointment.

We look forward to seeing you on:

Day _____ Date _____ Time _____

(Please arrive 20 minutes prior to your scheduled appointment time.)

Videotaping or photography is not allowed. Patients having a sonogram will be given a CD or photographs of their baby's images.



Darren M. Farley, M.D., F.A.C.O.G.

3232 East Murdock, 2nd Floor Wichita, KS 67208 P - (316) 239-2850 F - (316) 239-2852

HEALTH HISTORY QUESTIONNAIRE



Name _____ Birthdate _____

Reason For Visit: _____ Primary Care Physician: _____

Pharmacy #1: _____ City: _____ Location: _____

Pharmacy #2: _____ City: _____ Location: _____

Age when you started having periods: _____ Date of Last Menstrual Period: _____

Number of pregnancies _____ Full term deliveries _____ Pre term deliveries _____

Miscarriage/Abortions _____ Living Children _____

Medication allergies and **reaction**: _____

Please include all over the counter medications and prescription medications.

Medication	Dose/Strength	# of pills/amt	times/day

Medical History

Please check if you have or have ever been diagnosed with any of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Clot
<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Chronic Urinary Infection
<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Diabetes (type _____)
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Elevated Cholesterol
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Angina
<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> Coronary artery disease
<input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Hepatitis (type _____)
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Lupus
<input type="checkbox"/> Migraines
<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Obsessive/Compulsive
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Hyperthyroid
<input type="checkbox"/> Goiter
<input type="checkbox"/> Other _____

_____ |
|---|--|

- | | |
|---|---|
| <input type="checkbox"/> Depression
<input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Graves Disease |
|---|---|

GYN PROBLEMS

- Abnormal Pap Smears
- Bartholin Cyst
- Breast Cancer
- Breast Lump
- Cervical Cancer
- Cervical Dysplasia
- Chronic Vaginal Infections
- Chronic Pelvic Pain
- Endometrial Hyperplasia
- Endometriosis
- Fibrocystic Breast
- Habitual Aborter(> 3 Miscarriages)
- Infertility
- Ovarian Cancer
- Ovarian Cyst

- Heavy Bleeding
- Irregular Period
- Lichen Sclerosus
- Pelvic Inflammatory Disease
- Prolapse
- Sexually Transmitted Disease
 - Chlamydia
 - Genital Warts
 - Gonorrhea
 - Herpes
 - Trichomonas
- Urinary Incontinence
- Uterine Cancer
- Uterine Fibroids
- Other _____

SURGICAL HISTORY

Have you ever had any of the following surgeries and if so when.

	Age	Yr
<input type="checkbox"/> Arthroscopy (_____)		
<input type="checkbox"/> Appendectomy/Appendix		
<input type="checkbox"/> Cataracts		
<input type="checkbox"/> Cardiac Surgery (_____)		
<input type="checkbox"/> Cystoscopy		
<input type="checkbox"/> Gallbladder Removed		
<input type="checkbox"/> Hip Replacement R or L		
<input type="checkbox"/> Knee Replacement R or L		

	Age	Yr
<input type="checkbox"/> Sinus Surgery		
<input type="checkbox"/> Tonsillectomy		
<input type="checkbox"/> Tonsillectomy/Adenoids		
<input type="checkbox"/> Tubes in ears		
<input type="checkbox"/> Wisdom Tooth Extraction		

GYN SURGICAL HISTORY

	Age	Yr
<input type="checkbox"/> Breast Augmentation		
<input type="checkbox"/> Breast Biopsy		
<input type="checkbox"/> Breast Reduction		
<input type="checkbox"/> Cesarean Section		
<input type="checkbox"/> Cervical Procedures		
<input type="checkbox"/> Cone Biopsy		
<input type="checkbox"/> Cryo		
<input type="checkbox"/> Laser		
<input type="checkbox"/> LEEP		
<input type="checkbox"/> Colposcopy		
<input type="checkbox"/> D & C		

	Age	Yr
<input type="checkbox"/> Endometrial Ablation		
<input type="checkbox"/> Hysteroscopy		
<input type="checkbox"/> Hysterectomy Abd / Vag		
<input type="checkbox"/> Laparoscopy		
<input type="checkbox"/> Laparotomy		
<input type="checkbox"/> Mastectomy R / L / B		
<input type="checkbox"/> Ovaries Removed R / L / B		
<input type="checkbox"/> Tubal Ligation		

SOCIAL HISTORY

Marital Status: Married Divorced Legally Separated Single Widowed
 Engaged Domestic Partner

Occupation: _____ Unemployed Disabled

Place of Employment: _____

Race: African-American Asian Caucasian Hispanic Other: _____

Diet: Diabetic Healthy High Fat Low Fat Low Sodium Junk Food

Exercise: 2-3x/week 3-4x/week Daily Never Occasional Rarely

Tobacco Use: No Yes Former
Type: _____ Amt/day: _____ #Years: _____ Year Quit: _____

Alcohol Use: No Yes Former
Frequency: _____ Year Quit: _____

Illicit Drug Use: No Yes Former
Type: _____ #Years: _____ Year Quit: _____

Have you ever had chicken pox? Yes No I had the vaccine Unknown

Do you have cats? No Indoor Only Indoor/Outdoor Outdoor

Father of Baby: _____

Father of Baby's Race: African-American Asian Caucasian Hispanic
 Other: _____

HEALTH MAINTENANCE

Date of Last Pap Smear: _____ **Result:** _____

Chicken Pox Status: I have had chicken pox I have had the chicken pox vaccine
 I have had the vaccine and chicken pox I have had neither the vaccine nor chicken pox

Hepatitis B: I have received the entire Hepatitis B vaccination series
 I have part of the Hepatitis B vaccination series
 I have not received the Hepatitis B vaccination series

Flu Vaccine: I have received the Flu vaccine this year.

Pneumonia Vaccine: I have received a vaccine for Pneumonia.

Year of Last Tetanus Vaccine: _____

GENETIC HISTORY

Please check if anyone in your immediate family or the baby's father's family has been diagnosed or treated for the following:

Abbreviations: MOB (Mother of the Baby)
 FOB (Father of the Baby)

	Previous Child	MOB	MOB, Mother	MOB, Father	MOB, Sister	MOB, Brother	FOB	FOB, Mother	FOB, Father	FOB, Sister	FOB, Brother
Thalassemia											
Neural Tube Defect											
Congenital Heart Defect											
Down Syndrome											
Tay-Sachs											
Canavan Disease											
Sickle Cell											
Hemophilia											
Muscular Dystrophy											
Cystic Fibrosis											
Mental Retardation											
Autism											
PKU											
Recurrent Miscarriage											
Stillborn Infant											