



**Med Center  
Health.**

**Women's Health Specialists**

Medical Arts Building • 350 Park Street, Suite 203  
 Bowling Green, KY 42101  
 Phone: (270) 781-0075 • Fax: (270) 781-0143  
 Toll Free: 1-866-997-5784  
[MedCenterHealth.org](http://MedCenterHealth.org)

**NEW OB PATIENT PACKET**

Congratulations on your pregnancy and “Thank You” for choosing Women’s Health Specialists to provide quality care to you and your unborn child.

At your first prenatal appointment, we set aside plenty of time to devote our attention totally to you and to understanding your needs and concerns. We view good health as a partnership, which requires close involvement and good communication between you and your provider. Please understand that this first appointment usually takes at least an hour to complete as a complete health history will be reviewed for the mother and father of the baby, as well as a full physical of the mother, usual lab work, and in some cases an Ultrasound.

Early detection of any disease or illness usually means early treatment and a higher success rate. Thus, appointments that are not kept pose an increased risk to your health as well as the health of your unborn child. If you are unable to keep an appointment, please notify us as soon as possible. It is important you arrive on time for your scheduled appointment(s). Arriving late causes us to get behind schedule, which in turn makes all other patients’ appointments run late. Therefore, if you are late, we will require you to reschedule your appointment. Because of our concern with closely monitoring the health of all our patients, patients who fail to show up for an appointment or fail to call and reschedule more than two times may be discharged from the practice.

We also ask that you be patient with us and understand that we are an obstetrical practice, so unexpected delays may occur. While we try to keep these delays from interrupting your scheduled appointment, it is a natural occurrence that is beyond our control. If your provider has to leave the office, we may have to reschedule your appointment or ask you to see another provider during your routine prenatal appointment.

**Please complete the attached paperwork and bring it with you to your appointment along with your Insurance Card(s) and picture ID.** Completing all paperwork will expedite your appointment. If you are unable to complete the enclosed paperwork, please arrive earlier than requested to receive assistance in completion / processing. If you have any questions or concerns, always feel free to contact our office.

It is a pleasure to serve you and we look forward to seeing you in our office soon!

Appointment Date: \_\_\_\_\_

Time: \_\_\_\_\_

Provider: \_\_\_\_\_

Office Location: \_\_\_\_\_



*Please plan to arrive 30 minutes early for processing of all paperwork!*

*Thank You*





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## PARKING & ENTRANCE



Women's Health Specialists is located in the Medical Arts Building which is connected to The Medical Center. Although our address is Park Street, the Medical Arts Building entrance is on High Street. Designated parking for the Medical Arts Building is available on High Street.

*The gated parking lot for the Medical Arts Building is designated specifically for doctor offices in the building. It is **FREE** to use for our patients! Upon entering the parking lot, push the button to get a ticket. Bring this ticket to our office for staff to validate. Then, when exiting the parking lot, put the validated ticket into the gate's slot.*

Women's Health Specialists is located in Suite 203, on the second floor of the Medical Arts Building. If you have problems locating us, please feel free to call our office for directions.

Patients are also seen in Franklin, Scottsville & Caverna on select days.

The Medical Center at  
 Franklin  
 Physician Specialty Clinics  
 Franklin Medical Plaza  
 1100 Brookhaven Road  
 Franklin, KY 42134

The Medical Center at Caverna  
 Physician Specialty Clinics  
 1501 South Dixie Street  
 Horse Cave, KY 42749

The Medical Center at  
 Scottsville  
 Physician Specialty Clinics  
 456 Burnley Road  
 Scottsville, KY 42164



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**PATIENT INFORMATION (Please Print)**

**Patient Name** \_\_\_\_\_  
(Last, First, Middle Initial)

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

Marital Status (Please Circle) Single Married Widowed Divorced Separated

Mailing Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Preferred Method to Confirm Appointments (Please Circle one) Text Home Phone Cell Phone Work Phone

Employer \_\_\_\_\_ Occupation (Indicate if a Student) \_\_\_\_\_

**Name of Insured or Parent** \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last, First, Middle Initial)

Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Emergency Contact Name** \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite Insurance Carrier payments. The patient is responsible for all fees, regardless of Insurance Coverage. Payment is due at the time services are rendered unless other arrangements have been made in advance. KRS 194A.505 requires every person to disclose all sources of Insurance Coverage, at each visit. Failure to do so is fraudulent. Our office is required and will report all such misrepresentations.

**INSURANCE AUTHORIZATION (Please Read & Sign)**

I HEARBY AUTHORIZE WOMEN'S HEALTH SPECIALISTS TO FURNISH TO INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENT'S) ILLNESS AND TREATMENT AND I HEARBY ASSIGN TO WOMEN'S HEALTH SPECIALISTS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

\_\_\_\_\_  
Signature of Patient or Parent

\_\_\_\_\_  
Date



# Med Center Health

Women's Health Specialists

Patient Name _____
Date of Birth _____ Age _____
Social Security # _____
Marital Status (Please Circle) S M W D S Race _____
Patient Occupation _____
Highest Level of Education Completed _____

## GYNECOLOGICAL / OBSTETRICAL HISTORY

Baby's Father Name \_\_\_\_\_ Phone # \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Baby's Father's Occupation / Employer \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

## GENERAL HISTORY – SELF & FAMILY

Please mark if you or any family member (children, sisters, brothers, grandparents, aunts, uncles) have had any of the following conditions. **IF YOU ARE UNSURE OF A CONDITION, PLEASE CIRCLE IT.**

Self	Family	Condition	Self	Family	Condition
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Twins
<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Infertility
<input type="radio"/>	<input type="radio"/>	Heart / Valve Disease	<input type="radio"/>	<input type="radio"/>	Blood Clots / Varicose Veins
<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>	Blood Transfusions
<input type="radio"/>	<input type="radio"/>	Lung Disease	<i>Sexually Transmitted Diseases:</i>		
<input type="radio"/>	<input type="radio"/>	Stomach / Bowel Problems	<input type="radio"/>		Genital Herpes
<input type="radio"/>	<input type="radio"/>	Kidney Disease	<input type="radio"/>		Condylomata (Genital Warts)
<input type="radio"/>	<input type="radio"/>	Urinary Problems	<input type="radio"/>		Chlamydia
		(including infections/malformations)	<i>Infectious Disease:</i>		
<input type="radio"/>	<input type="radio"/>	Diabetes Mellitus	<input type="radio"/>		Hepatitis
<input type="radio"/>	<input type="radio"/>	Anemia / Blood Disorders	<input type="radio"/>		Turberculosis
<input type="radio"/>	<input type="radio"/>	Other Endocrine / Hormone Disorders	<i>Other Diseases or Illnesses:</i>		
<input type="radio"/>	<input type="radio"/>	Nervous / Mental Disorders	<input type="radio"/>		PKU
<input type="radio"/>	<input type="radio"/>	Convulsive Disorders / Epilepsy	<input type="radio"/>		DES Exposure
<input type="radio"/>	<input type="radio"/>	Abnormal Babies	<input type="radio"/>		Other _____
<input type="radio"/>	<input type="radio"/>	Genetic Diseases			

Does the baby's father, or his family, have any history of abnormal babies or genetic disease?  Yes  No

Are you ever around cats?  Yes  No      Do you have a hot tub?  Yes  No

Do you exercise regularly?  Yes  No      Do you, or have you, used drugs (marijuana, cocaine, etc)?  Yes  No

**TOBACCO & CAFFEINE**      **ALCOHOL**      **ALLERGIES/SENSITIVITIES**

Coffee/Tea \_\_\_\_\_ cups a day      Do you drink Alcohol?      Antibiotics: \_\_\_\_\_

Cola or other caffeinated drinks \_\_\_\_\_ a day       Yes  No      Pain Medication: \_\_\_\_\_

Cigarettes – Now \_\_\_\_\_ a day \_\_\_\_\_ years      \_\_\_\_\_ Drinks a day      Anesthesia: \_\_\_\_\_

Cigarettes – Ever \_\_\_\_\_ a day \_\_\_\_\_ years      \_\_\_\_\_ Drinks a week      Other: \_\_\_\_\_

When stopped: \_\_\_\_\_

Please list all times you have been hospitalized, operated on, or seriously injured

Year	Operation, Illness, or Injury	Hospital & City

Pregnancy History				Grav		Term	Preterm	Abortion	Living	C.Section
No. of Preg	Mo / Yr	Baby's Sex	Birth Wgt	Wks Gestat.	Hrs. Labor	Delivery Type	Detail Complications - Maternal / Newborn / Anesthesia if a C.Section, list incision type			
1										
2										
3										
4										
5										
6										



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## HEALTH PROFILE

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
(Last, First, Middle Initial)  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Why are you seeing the Doctor? \_\_\_\_\_  
When was the first day of your last menstrual period? \_\_\_\_\_  
How often do you get your period? \_\_\_\_\_ How long does the bleeding last? \_\_\_\_\_  
How severe is the cramping with your period (none / mild / severe)? \_\_\_\_\_  
Are you doing anything for Birth Control right now? Yes No If yes, what? \_\_\_\_\_  
When was your last PAP smear? \_\_\_\_\_ Ever had an abnormal PAP? Yes No When? \_\_\_\_\_  
When was your last Mammogram? \_\_\_\_\_ Ever had an abnormal mammogram? Yes No When? \_\_\_\_\_  
What medications are you currently taking (name & dose)? \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Location (City, State) \_\_\_\_\_  
Do you smoke? Yes No If yes, how many packs of cigarettes per day? \_\_\_\_\_  
Do you use alcohol (beer, wine, etc.)? Yes No If yes, what kind? \_\_\_\_\_  
How many times have you been pregnant? \_\_\_\_\_ How many babies have you delivered? \_\_\_\_\_  
How many miscarriages have you had? \_\_\_\_\_ How many abortions have you had? \_\_\_\_\_  
Have you ever had a Cesarean Section? Yes No  
What surgeries have you had? (Please list all & year) \_\_\_\_\_

Do you have any medical problems (i.e. Diabetes, thyroid disease, high blood pressure, heart disease, asthma, joint problems, etc.)? Please list any \_\_\_\_\_

Do you have a history of seizures? \_\_\_\_\_  
Has anyone in your family had any of the following problems?  
Cancer \_\_\_\_\_ Who \_\_\_\_\_ What kind / location (i.e. breast, colon, etc.) \_\_\_\_\_  
Diabetes \_\_\_\_\_ Who \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Who \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Who \_\_\_\_\_ Asthma \_\_\_\_\_ Who \_\_\_\_\_

Any other major medical problems to note, Please list \_\_\_\_\_

### Latex Allergy Screening Tool

1. Do you have a confirmed latex sensitivity, or do you have spina bifida? Yes No
2. Have you ever had a reaction after handling/using poinsettia plants, balloons, rubber products or spandex? Yes No
3. Have you ever had one of the following after a medical /dental appointment: itching, tearing, fatigue, sneezing or running nose? Yes No
4. Have you ever reacted after eating bananas, avocados, kiwi, or chestnuts? Yes No

For patients who have responded in the affirmative to most of these questions, latex precautions will be utilized, unless otherwise stipulated by the physician. The suspected allergy will be documented in the patient's chart and the referring physician will be contacted.

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