CHICAGO women's HEALTH GROUP

Genetic Screening Questionnaire

Name: _____ Date: _____

Instructions: Please answer the following questions to the best of your ability. Your healthcare provider will review the information given at your visit. Thank you.

1. Will you be 35 years or older when the baby is due? Yes ☐ No ☐

2. Age of father/sperm donor of the child: _____

3. What is your ethnicity/ancestry?

☐ Ashkenazi Jewish
☐ Asian
☐ Black/African American
☐ French Canadian
☐ Hispanic/Latinx
☐ Mediterranean
☐ Native American or Alaska Native
☐ Pacific Islander or Native Hawaiian
☐ Sephardic Jewish
☐ White/Caucasian
Other: _____

4. What is the ethnicity/ancestry of the father/sperm donor?

☐ Ashkenazi Jewish
☐ Asian
☐ Black/African American
☐ French Canadian
☐ Hispanic/Latinx
☐ Mediterranean
☐ Native American or Alaska Native
☐ Pacific Islander or Native Hawaiian
☐ Sephardic Jewish
☐ White/Caucasian
Other: _____

5. Do you have any religious reasons that you cannot receive blood products/transfusions? Yes ☐ No ☐

6. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:

- Neural tube defect, i.e., spina bifida (myelomeningocele or open spine), anencephaly — Yes ☐ No ☐
- Congenital heart defect — Yes ☐ No ☐
- Down syndrome — Yes ☐ No ☐
- Tay-Sachs — Yes ☐ No ☐
- Canavan disease — Yes ☐ No ☐
- Sickle cell disease — Yes ☐ No ☐
- Hemophilia — Yes ☐ No ☐
- Muscular dystrophy — Yes ☐ No ☐
- Cystic fibrosis — Yes ☐ No ☐

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7. Do you or the baby's father have any close relatives with intellectual disability or autism?	Yes ☐	No ☐
8. Do you or the baby's father have any close relatives with Fragile X?	Yes ☐	No ☐
9. Do you or the baby's father have diabetes, metabolic syndrome, celiac disease, PKU, or any other disorder that prevents you from metabolizing food without assistance?	Yes ☐	No ☐
10. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal disorder not listed above?	Yes ☐	No ☐
11. In this or any previous relationships, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses?	Yes ☐	No ☐
12. Have you ever had chicken pox?	Yes ☐	No ☐
13. Have you or the baby's father ever had or been treated for a sexually transmitted disease, such as chlamydia, herpes, gonorrhea, syphilis?	Yes ☐	No ☐
14. Have you or the baby's father ever had a positive test for HIV or been exposed to AIDS?	Yes ☐	No ☐
15. Have you ever had or tested positive for tuberculosis?	Yes ☐	No ☐
16. Are you and the baby's father related (besides marriage)?	Yes ☐	No ☐
17. Have you or the baby's father ever had hepatitis?	Yes ☐	No ☐
18. Do you work in the healthcare field?	Yes ☐	No ☐
19. Do you have cats?	Yes ☐	No ☐
20. Do you garden?	Yes ☐	No ☐
21. Have you traveled outside the country during pregnancy?	Yes ☐	No ☐
22. Have you had gestational diabetes in a previous pregnancy?	Yes ☐	No ☐
23. Have you taken any prescribed medication, over-the-counter medications, recreational drugs, or alcohol since your last menstrual period? If yes, please list medication and dose. _____	Yes ☐	No ☐
24. Have you had any previous pregnancies with a different practice? If yes: Date of delivery: _____ How many weeks when deliver: _____ Vaginal or Caesarean section: _____ Weight of baby: _____	Yes ☐	No ☐

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

add columns _____ + _____ + _____

Total Score _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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OBSTETRIC ULTRASOUND POLICY

During your pregnancy, you will most likely have several ultrasounds. You are encouraged to discuss these scans with your doctor, who will be happy to explain the reason each scan will be important for you.

You will have your first ultrasound at your first prenatal visit to establish dates and to make sure that all looks normal with the pregnancy.

Your second one may be the Nuchal Translucency scan. This scan looks at your baby's neck and helps to assess the risk for Down Syndrome and other genetic problems in the baby. This scan is optional.

The next scan is at approximately 20 weeks. This is an anatomy scan. Our sonographers will look over your baby from head to toe to look for anything that may not be developing normally. Also done at this time is a scan to check the length of your cervix, which can indicate whether your cervix may not be competent to hold the baby to term.

Another ultrasound scan is usually done around 36 weeks to check the size of your baby and to make sure everything looks as it should.

The cost of ultrasound is $400-500 per scan. These will be billed to your insurance carrier.

If you are having any health issues or problems with your pregnancy, additional scans may be needed.

Recently, we have found that insurance is limiting the number of ultrasounds that they will cover. While our ultrasounds are billed with the appropriate procedure and diagnosis codes, we are finding that insurance is occasionally denying coverage. Any ultrasound scans not covered by your insurance will be your responsibility.

Please sign below indicating that you have read and understand our ultrasound policy.

Thank you.

Chicago Women's Health Group

Patient's name: _____

Signature: _____

Date: _____

Past Pregnancies/Deliveries

Date (month and year): ______________

Weeks: ____________________________

Length of labor: ____________________

Birth weight: _______________________

Type of delivery: C-section ☐ Vaginal delivery ☐

Do you use anesthesia? Yes ☐ No ☐

If yes, please indicate which type: __________________________

Place of delivery: ____

Did you experience complications? Yes ☐ No ☐

If yes, please specify (bleeding, vacuum/forceps delivery, shoulder dystocia, *etc.*):

____

Date (month and year): ______________

Weeks: ____________________________

Length of labor: ____________________

Birth weight: _______________________

Type of delivery: C-section ☐ Vaginal delivery ☐

Do you use anesthesia? Yes ☐ No ☐

If yes, please indicate which type: __________________________

Place of delivery: ____

Did you experience complications? Yes ☐ No ☐

If yes, please specify (bleeding, vacuum/forceps delivery, shoulder dystocia, *etc.*):

____

Date (month and year): ______________

Weeks: ____________________________

Length of labor: ____________________

Birth weight: _______________________

Type of delivery: C-section ☐ Vaginal delivery ☐

Do you use anesthesia? Yes ☐ No ☐

If yes, please indicate which type: __________________________

Place of delivery: ____

Did you experience complications? Yes ☐ No ☐

If yes, please specify (bleeding, vacuum/forceps delivery, shoulder dystocia, *etc.*):

____

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After the delivery, our office will submit charges for your obstetrical care and delivery to your insurance carrier. Your deposit will be applied toward any portion of charges not covered by insurance.

- If a balance remains after application of your deposit, you will be responsible for the outstanding amount.
- If your deposit results in an overpayment, the excess will be refunded to you.

Cancellation, Returned Check, and Payment Policy

- **Appointment cancellations:** Appointments must be canceled or rescheduled at least **24 hours in advance.** Failure to provide timely notice will result in a **$50 late cancellation/no-show fee for doctor appointment** and **$100 fee for ultrasound or physical therapy appointment.**
- **Returned checks:** A **$40 fee** will be assessed for each returned check.
- **Outstanding balances:** All outstanding balances must be paid at the time of each visit. Failure to make payment may result in cancellation of your appointment unless a payment plan has been arranged with our billing department in advance.

Patient Responsibility

I acknowledge that certain routine or recommended services may not be considered medically necessary for my insurance carrier and therefore may not be covered under my policy. I consent to receiving any services that my healthcare provider deems necessary for my care and agree to be financially responsible for charges not covered by my insurance.

I have read, understand, and agree to the terms outlined in the **Obstetrics Billing Policy.** My signature below confirms my acceptance of these terms and my financial responsibility for all charges incurred.

Patient's name: _____

Signature: _____

Date: _____