

**Tripler Army Medical Center
And
Schofield Barracks**

Department of Obstetrics

OB Registration Packet



**Please complete prior to attending your initial OB
appointment.**

**Tripler Army Medical Center Central Appointment
Line: 433-2778, Option 1-2**

Schofield Barracks OB Appointment Line: 433-8794

OBSTETRIC CARE
at
Tripler Army Medical Center
and
Schofield Barracks
OB Clinics

Congratulations from the staff of Tripler Army Medical Center & Schofield Barracks OB Clinics. We would like to share the care options you have here. Please consider which option would best meet your needs and let us know which option you prefer:

You have options when choosing your OB care:

1. Tripler Army Medical Center: Uncomplicated and Complicated (high risk) OB care for the duration of your pregnancy.
2. Schofield Barracks OB Clinic: You can receive your OB care up to 40 weeks as long as there are no complications. Every attempt will be made to provide continuity of care; however, OB Staffs and Residents will be rotating through the clinic.
3. Certified Midwife Program (Tripler only): Allows you to be seen by the Nurse Midwives during your pregnancy and then have a midwife on call present for the birth of your baby. You must meet specific program criteria to be enrolled. If you are interested, request an appointment with one of the midwives and discuss your interest with them. These appointments are limited to women who have a low risk of needing any intervention during delivery.

Your baby will not necessarily be delivered by the Provider that you see in the clinic as all Providers rotate through Labor & Delivery.

INFORMATION SHEET & CONSENT FORM
ROUTINE ADJUNCT PATIENT SCREENING PROGRAM FOR HIV INFECTION

1. The Army has initiated a program for screening patients for the presence of HIV (Human Immunodeficiency Virus) infection. HIV is the virus that causes AIDS. Routine testing assists physicians in being fully aware of a patient's health status, helps prevent the spread of infection, and provides important information on the distribution of disease.
2. This HIV screening program is mandatory for active duty military members. AD will have their blood drawn and tested unless there is military documentation of an HIV test result within the previous 12 months.
3. This HIV screening program is voluntary for non-active duty beneficiaries of military medical care. As a civilian you have the absolute right to refuse to have this blood test performed. No patient who declines screening under this program will be denied appropriate care.
4. The screening test for HIV antibody requires that a blood sample be obtained using a needle and syringe.
5. The blood sample obtained is tested for the presence of HIV and antibodies. The presence of HIV antibodies means one is infected with the AIDS virus. It *does not* mean that one has the *disease* AIDS.
6. A NEGATIVE TEST means that no antibodies to the AIDS virus have been found in your blood at this time. There are three possible explanations for this:
 - You have not been exposed to the virus.
 - You have been exposed to the virus, but have not been infected and therefore you have not produced antibodies.
 - You have recently been infected by the virus but your body has not made enough antibodies to be detected yet.
7. A POSITIVE TEST means that:
 - Your blood has been tested and retested and the tests show that antibodies to HIV have been found in your blood.
 - You have been exposed to the HIV and your body has made antibodies.
 - You can pass the virus on to others.
8. A person identified as HIV antibody positive could infect others through sexual activity, pregnancy, or contact from body fluids (including blood). This person should also have an adverse reaction to certain drugs, immunizations, and prenatal, dental, medical and surgical treatments.
9. If your test is positive, you will be notified by your doctor and receive additional medical evaluation and counseling.
10. The results of a confirming, positive screening test will be placed in your medical record and appropriate persons involved in health care will have access to that information. The HIV test results are considered confidential and the test results in the medical record shall not be released without the patient's written permission, except to the individuals and organizations who are authorized access under state and federal laws or regulations.
11. You will be provided with an educational handout that provides basic information regarding AIDS and are encouraged to ask questions of your doctor.

(See reverse)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE TAMC Prenatal Genetic Screen*	OTSG APPROVED (Date) (YYYYMMDD) 4 Nov 87
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Date _____

1. Will you be 35 years or older when the baby is due? Yes _____ No _____
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?

Down syndrome (mongolism)	Yes _____ No _____
Other chromosomal abnormality	Yes _____ No _____
Neural tube defect, i.e., spina bifida (meningomyelocele or open spine), anencephaly	Yes _____ No _____
Hemophilia	Yes _____ No _____
Muscular dystrophy	Yes _____ No _____
Cystic fibrosis	Yes _____ No _____

 If yes, indicate the relationship of the affected person to you or to the baby's father: _____
3. Do you or the baby's father have a birth defect? Yes _____ No _____
 If yes, who has the defect and what is it? _____
4. In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2 above? Yes _____ No _____
 If yes, what was the defect and who had it? _____
5. Do you or the baby's father have any close relatives with mental retardation? Yes _____ No _____
 If yes, indicate the relationship of the affected person to you or to the baby's father: _____
 Indicate the cause, if known: _____
6. 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 abnormality not listed above? Yes _____ No _____
 If yes, indicate the condition and the relationship of the affected person to you or to the baby's father: _____
7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes _____ No _____
 Have either of you had a chromosomal study? Yes _____ No _____
 If yes, indicate who and the results: _____
8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes _____ No _____
 If yes, indicate who and the results: _____
9. If you or the baby's father are black, have either of you been screened for sickle cell trait? Yes _____ No _____
 If yes, indicate who and the results: _____
10. If you or the baby's father are Italian, Greek, or Mediterranean background, have either of you been tested for β -thalassemia? Yes _____ No _____
 If yes, indicate who the results: _____
11. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for α -thalassemia? Yes _____ No _____
 If yes, indicate who and the results: _____
12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (include nonprescription drugs.) Yes _____ No _____
 If yes, give name of medication and time taken during pregnancy: _____

*Any patient replying "YES" to questions should be offered appropriate counseling. If the patient declines further counseling or testing, this should be noted in the chart.

Patient request Genetic Counseling Yes _____ No _____

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC Department of Obstetrics-Gynecology	(Continue on reverse) DATE (YYYYMMDD)
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)	<table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> HISTORY/PHYSICAL</td> <td><input type="checkbox"/> FLOW CHART</td> </tr> <tr> <td><input type="checkbox"/> OTHER EXAMINATION OR EVALUATION</td> <td><input type="checkbox"/> OTHER (Specify)</td> </tr> <tr> <td><input type="checkbox"/> DIAGNOSTIC STUDIES</td> <td></td> </tr> <tr> <td><input type="checkbox"/> TREATMENT</td> <td></td> </tr> </table>	<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> FLOW CHART	<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER (Specify)	<input type="checkbox"/> DIAGNOSTIC STUDIES		<input type="checkbox"/> TREATMENT	
<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> FLOW CHART								
<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER (Specify)								
<input type="checkbox"/> DIAGNOSTIC STUDIES									
<input type="checkbox"/> TREATMENT									

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE

OB Registration

Please fill this form out completely before your appointment with the nurse.

Your Last Name <input style="width: 95%;" type="text"/>	First Name <input style="width: 95%;" type="text"/>	THE SPONSOR'S SSN <input style="width: 95%;" type="text"/>
Marital Status	Ethnicity	Primary Language Your Date of Birth
<input type="checkbox"/> Married	<input type="checkbox"/> Caucasian	<input type="checkbox"/> English ____/____/____
<input type="checkbox"/> Single	<input type="checkbox"/> African American	<input type="checkbox"/> _____
<input type="checkbox"/> Divorced	<input type="checkbox"/> Filipino	Check one: (you are)
<input type="checkbox"/> Widowed	<input type="checkbox"/> Korean	<input type="checkbox"/> Dependent
	<input type="checkbox"/> Japanese	<input type="checkbox"/> Active Duty _____
	<input type="checkbox"/> Samoan	(O-1, E-1, etc)
	<input type="checkbox"/> Chinese	
	<input type="checkbox"/> Mexican	
	<input type="checkbox"/> Hispanic	
	<input type="checkbox"/> Native American	
	<input type="checkbox"/> Pacific Islander	
	<input type="checkbox"/> _____	
		Religious Preference
		<input type="checkbox"/> _____

Sponsor's:		
Branch of Service: _____	Base/Post Stationed at: _____	Military Unit: _____

Husband / Sponsor's Last Name <input style="width: 95%;" type="text"/>	First Name <input style="width: 95%;" type="text"/>	Date of Birth ____/____/____	Check one
			<input type="checkbox"/> Dependent
			<input type="checkbox"/> Active Duty _____
			(O-1, E-1, etc)
Father of Baby is	<input type="checkbox"/> Aware of my pregnancy	Father's Ethnicity: _____	
	<input type="checkbox"/> Supportive of pregnancy		

Address:	PCS/DEROS: <input style="width: 95%;" type="text"/>
<input style="width: 95%;" type="text"/> Street	
<input style="width: 95%;" type="text"/> City, State, Zip	
<input style="width: 95%;" type="text"/> Home Phone	<input style="width: 95%;" type="text"/> Work Phone

Please rank the following according to your daily use:

Smoking: (per day)	<input type="checkbox"/> Never	<input type="checkbox"/> Recently Quit	<input type="checkbox"/> Light <small>< one pack</small>	<input type="checkbox"/> Moderate <small>1-1.5 pack</small>	<input type="checkbox"/> Heavy <small>1.5-2 packs</small>	<input type="checkbox"/> Very Heavy <small>>2 packs</small>
Illicit Drug Used:	<input type="checkbox"/> Never	<input type="checkbox"/> Recently Quit	<input type="checkbox"/> Light <small>1-2 times/year</small>	<input type="checkbox"/> Moderate <small>3-4</small>	<input type="checkbox"/> Heavy <small>4-5</small>	<input type="checkbox"/> Very Heavy <small>>5</small>
Alcoholic Beverages:	<input type="checkbox"/> Never	<input type="checkbox"/> Recently Quit	<input type="checkbox"/> Light <small>1-2 drinks/month</small>	<input type="checkbox"/> Moderate <small>3-4</small>	<input type="checkbox"/> Heavy <small>4-5</small>	<input type="checkbox"/> Very Heavy <small>>5</small>
Caffeinated Beverages:	<input type="checkbox"/> Never	<input type="checkbox"/> Recently Quit	<input type="checkbox"/> Light <small>1-2 times/day</small>	<input type="checkbox"/> Moderate <small>3-4</small>	<input type="checkbox"/> Heavy <small>4-5</small>	<input type="checkbox"/> Very Heavy <small>>5</small>

I am taking: Prenatal Vitamins Iron Supplements Folic Acid

Please list any other medications, vitamins or herbal supplements that you take on a regular basis

Please let us know if you have any problems with the following parts of your body by checking the block and giving a short description, to include dates.

- GENERAL _____
- HEAD/MIGRAINES _____
- EYES/GLASSES/CONTACTS _____
- EAR _____
- NOSE _____
- NECK _____
- THROAT _____
- LUNGS _____
- HEART _____
- STOMACH/INTESTINES/BOWEL MOVEMENTS _____
- URINARY/KIDNEYS/URINARY TRACT INFECTIONS _____
- GYN/UTERUS/OVARIES/CERVIX/ABNORMAL PAP SMEARS _____
- BLOOD/ANEMIA/SICKLE CELL/HEPATITIS _____
- LYMPH _____
- MUSCLES/BACK _____
- NEURO/PSYCH/ANXIETY/DEPRESSION/EATING DISORDERS _____
- HISTORY DRUG/ALCOHOL ABUSE TREATMENT _____
- OTHER _____

Please check the box if you have ever been treated for any of the following: (Include dates)

- HYPERTENSION/PRE-ECLAMPSIA _____
- HERPES _____
- SEXUALLY TRANSMITTED DISEASES _____
- BLOOD TRANSFUSION _____
- MORE THAN TWO URINARY TRACT INFECTIONS IN ONE YEAR _____
- SEIZURE _____
- THYROID PROBLEMS _____
- ASTHMA _____
- DIABETES _____
- CARDIAC PROBLEMS _____
- PULMONARY PROBLEMS / TUBERCULOSIS (TB) _____

Do you own any cats? YES NO

Please check the box if you (**the mother**) has a family history of any of the following.
If you do, state the relationship to you. Remember, we only need to know if it is on your side of the family.

- TWINS _____
- BIRTH DEFECTS _____
- DIABETES _____
- CANCER _____
- HEART DISEASE _____
- HIGH BLOOD PRESSURE _____

Are you allergic to any food or medication? YES NO

If yes, please write what you are allergic to and what happens to you.

I have had the following childhood illnesses:

(Please check the appropriate box or boxes.)

NONE CHICKEN POX MEASLES MUMPS RHEUMATIC FEVER

Please list any past operations/surgeries that you have had.

Include the month and year they occurred.

First day of your last menstrual period: _____ Height: _____ Usual Weight: _____

Including this pregnancy, how many times have you been pregnant? _____

How many children do you have now? _____

How old were you when you had your first period? _____

Are your periods REGULAR IRREGULAR

How often did your periods occur? Every _____ days.

Rate the amount of pain that you experience with your menstrual cycle.

NONE MILD MILD-MODERATE MODERATE SEVERE IRREGULAR

How many days do you bleed for during your menstrual period? _____

Past Pregnancies: Please fill out the chart below. Include any miscarriage or elective terminations that you have had.

Date	How many weeks you were at delivery	Hours of labor	Type of Anesthesia Used	Vaginal, C/S, Forceps, Vacuum	Hospital and State	Sex of Baby	Weight	Any Complications/ Hospitalizations During Pregnancy/Medication

Have you ever had a positive Tuberculosis or TB Tine Test? YES NO If yes, when: _____

Were you born outside of the United States? YES NO If yes, where: _____

Have you ever lived outside of the United States for more than 30 days? YES NO

Have you ever had active TB or lived with someone with active TB? YES NO

Have you ever taken any medications for TB? YES NO If yes, when: _____

If so, what medication(s) _____ How long? _____

Is this a planned pregnancy? Yes No

Are you experiencing any: NAUSEA VOMITING CRAMPING BLEEDING

How will you feed your baby? BREAST FEED BOTTLE FEED UNDECIDED

How would you describe your appetite? _____

Are you on any kind of special diet? NO YES. What kind? _____

Do you have any food cravings? NO YES. They are _____

Do you avoid any foods? NO YES. They are _____

How many times do you eat in one day? _____

What topic(s) do you want/need education on?

- | | |
|---|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Prenatal Care | <input type="checkbox"/> YES <input type="checkbox"/> NO Home Visiting Nurse |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Childbirth Preparation Classes | <input type="checkbox"/> YES <input type="checkbox"/> NO Couples Counseling |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Breastfeeding | <input type="checkbox"/> YES <input type="checkbox"/> NO Individual Counseling |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Infant Care | <input type="checkbox"/> YES <input type="checkbox"/> NO Stress/Anger Management |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Labor and Delivery Tour | <input type="checkbox"/> YES <input type="checkbox"/> NO Financial Planning |
| <input type="checkbox"/> YES <input type="checkbox"/> NO WIC | <input type="checkbox"/> YES <input type="checkbox"/> NO Single Parents Group |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Sibling Classes | <input type="checkbox"/> YES <input type="checkbox"/> NO Domestic Violence Treatment |

What is the best method of learning for you? Reading Videos Computer Demonstration

What is the highest school grade that you have completed? _____

Do you have any chronic pain issues/concerns? YES NO If so, explain: _____

Do you have any financial hardships that prevent you from getting medical care? YES NO

Do you have any cultural, language or religious preferences that would affect your care? YES NO

If yes: _____

During the past month, have you often been bothered by feeling down, depressed or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Do you have an Advance Medical Directive? YES NO

If no, are you interested in receiving information? YES NO

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

Advance Directive Assessment Form

OTSG APPROVED (Date)
(YYYYMMDD)

Section A: Introduction

As a patient, it is your right to provide Advance Directive concerning your wishes for life prolonging or life sustaining treatment in the event that you should become unable to make your own decisions. Two available options are:

- a. Medical Power of Attorney. This allows you to assign someone you trust to make decisions for you if the need arises
b. Living Will. This allows you to put your wishes in writing concerning life prolonging treatment.

*Both are highly recommended and are available through the legal assistance office (JAG).

Section B: Advance Directive Rights

Please initial all statements that apply to you.

- 1. I have been given information about my right to accept or refuse medical treatment.
2. I have been informed of my right to formulate an Advance Directive.
3. I understand that I am not required to have an Advance Directive.

Section C: Please initial your current status regarding Advance Directives: (ONLY ONE line should apply.)

- 1. I have completed an Advance Directive and have given a copy to Admissions and Dispositions.
2. I have completed an Advance Directive and will have someone bring a copy for my medical record.
3. I have an Advance Directive, but wish to speak to JAG to revise it.
4. I do not have an Advance Directive, but I understand I can speak to my physician regarding Advance Directive.
5. I do not have an Advance Directive and do not want one at the present time.

Section D: Signatures

1. Patient Signature: Date:
(Patient unable to sign; see comments below.)

2. A & D Signature: Date:
(Advance Directive information given to patient (Yes/No) or to person accompanying patient.)

Comments

*****ANNOTATE CHANGES ON REVERSE SIDE OF FORM*****

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

(Continue on reverse)
DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL
FLOW CHART
OTHER EXAMINATION OR EVALUATION
OTHER (Specify)
DIAGNOSTIC STUDIES
TREATMENT

Advance Directive Assessment Form (continued)

Section E: Changes to Original Status

Advance Directive (circle one of the following): added modified revoked

Date/Time: _____ Signature of Person annotating change: _____

Name of physician notified: _____ Date/Time: _____ Notified by whom: _____

Comments _____

Advance Directive (circle one of the following): added modified revoked

Date/Time: _____ Signature of person annotating change: _____

Name of physician notified: _____ Date/Time: _____ Notified by whom: _____

Comments _____

Advance Directive (circle one of the following): added modified revoked

Date/Time: _____ Signature of person annotating change: _____

Name of physician notified: _____ Date/Time: _____ Notified by whom: _____

Comments _____

Advance Directive (circle one of the following): added modified revoked

Date/Time: _____ Signature of person annotating change: _____

Name of physician notified: _____ Date/Time: _____ Notified by whom: _____

Comments _____

Additional Comments:
