

Women & Children

Maternal Fetal Medicine

Dear Patient and Family,

Welcome to Huntsville Hospital Maternal Fetal Medicine. Maternal Fetal Medicine, also referred to as perinatology, is the study and care of complicated and high risk pregnancies. Dr. Margaret Carter is double board certified in Obstetrics/Gynecology and in Maternal Fetal Medicine. She leads a team of clinical specialists including registered nurses and a registered medical sonographer specializing in high risk pregnancy scans.

There are many reasons a patient may be referred to our office. These may include:

- Routine prenatal diagnosis
- Maternal age of 35 and older
- Previous pregnancy complications
- Multiples
- Possible birth defect
- Family history of a genetic condition
- Chronic or acute medical disease such as diabetes, hypertension, autoimmune disease or clotting disorder
- Current obstetric condition such as short cervix, preterm labor or abnormal placenta
- At the request of your OB/GYN upon admission to the hospital with pregnancy complications

It's important for you to know that, even while you are a patient of this office, your primary obstetrician will continue with your pregnancy care and the delivery of your baby. Your initial appointment at Huntsville Hospital Maternal Fetal Medicine may take two hours. Please plan accordingly. Dr. Carter and her 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. All results that are available will be discussed with you during your appointment. Dr. Carter will also discuss those results and a plan of care, if indicated, with your primary obstetrician. It is not unusual for you to see Dr. Carter for only one visit, however, at anytime your doctor may refer you for another appointment, ultrasound or other testing.

We expect that you and your family will have questions. We encourage you to talk with our staff about your concerns so you can be informed and comfortable with the care we provide. It may help to write your questions down and bring them with you to your appointment.

We are looking forward to assisting you and your doctor during this pregnancy. If you have questions regarding your scheduled appointment, please call (256) 265-0880 to talk with one of our staff.

Sincerely,
Huntsville Hospital Maternal Fetal Medicine

Women & Children

Maternal Fetal Medicine

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.)

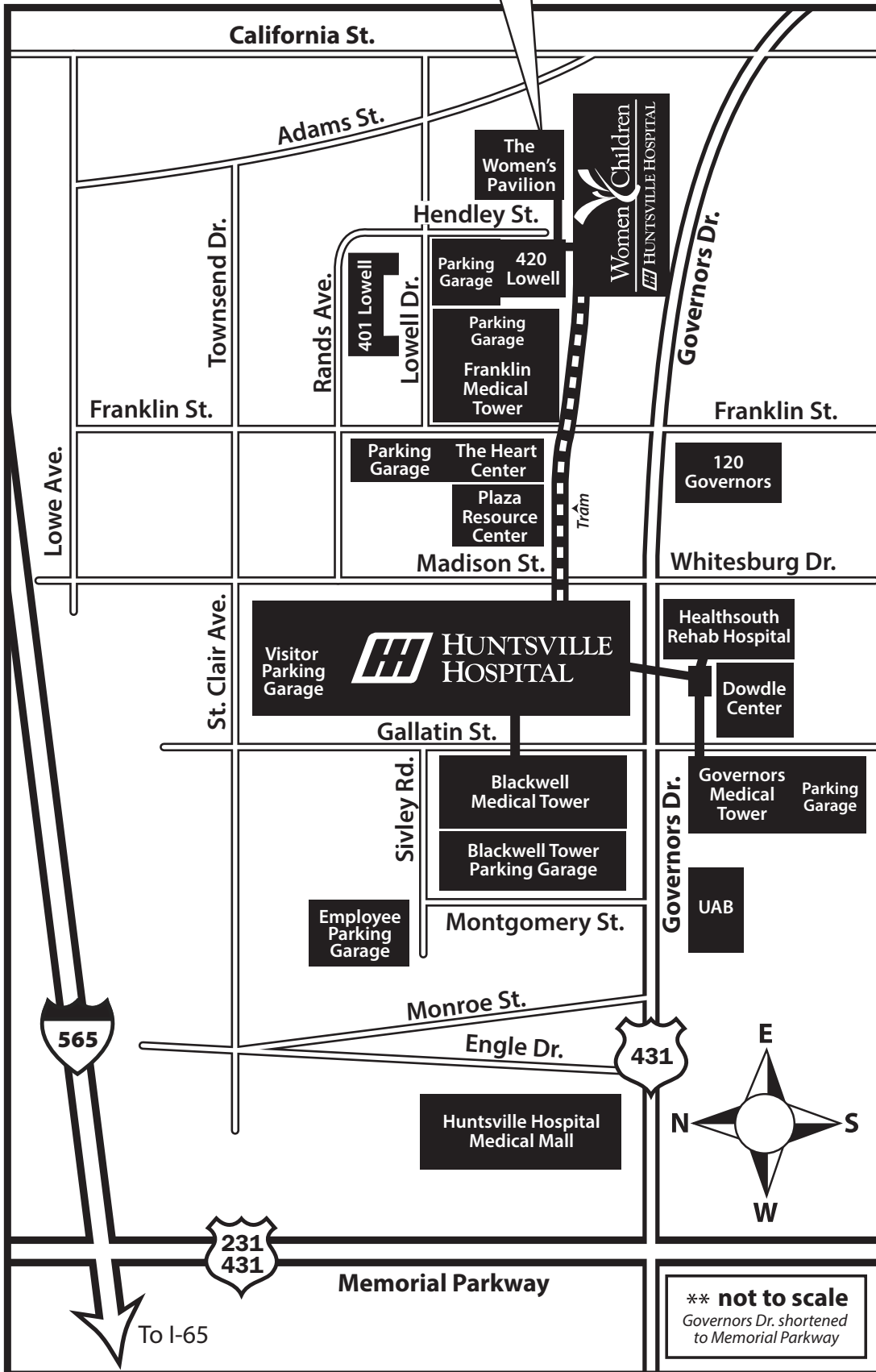
Videotaping or photography is not allowed. Patients having a sonogram will be given a CD or photographs of their baby's images.



Women & Children

Maternal Fetal Medicine

1st Floor



**** not to scale**
 Governors Dr. shortened
 to Memorial Parkway

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
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Bipolar Disorder
 <input type="checkbox"/> Obsessive/Compulsive </div> <div style="width: 45%;"> <input type="checkbox"/> Depression
 <input type="checkbox"/> Schizophrenia </div> </div> <input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Disorder
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Hyperthyroid
 <input type="checkbox"/> Goiter </div> <div style="width: 45%;"> <input type="checkbox"/> Hypothyroid
 <input type="checkbox"/> Graves Disease </div> </div> <input type="checkbox"/> Other _____

_____ |
|---|--|

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 <ul style="list-style-type: none"> <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		

OBSTETRICAL HISTORY

Please fill out for each pregnancy even if it was a miscarriage or abortion.

If you've had a tubal ligation, hysterectomy or are over the age of 50, only date and type of delivery are necessary.

Preg #	Type of Delivery	Date MM/YY	Baby Name	Gestational Age	Wt	Sex	Hospital	Doctor	Complications
	Miscarriage Vaginal Delivery C-Section Abortion			Term (> 37 weeks) Preterm (< 37 weeks)		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term (> 37 weeks) Preterm (< 37 weeks)		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term (> 37 weeks) Preterm (< 37 weeks)		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term (> 37 weeks) Preterm (< 37 weeks)		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term (> 37 weeks) Preterm (< 37 weeks)		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term (> 37 weeks) Preterm (< 37 weeks)		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term (> 37 weeks) Preterm (< 37 weeks)		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term (> 37 weeks) Preterm (< 37 weeks)		M / F			

FAMILY MEDICAL HISTORY

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

Adopted

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Diabetes										
Hypertension										
Stroke										
Heart Disease										
Thyroid Disorder										
Osteoporosis										
Epilepsy										
Kidney Problems										
Lung Disease										

Margaret F. Carter, M.D., M.Sc.

Board Certified OB/GYN & Maternal Fetal Medicine

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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											