



Great Lakes

Center for Maternal & Fetal Health

1701 South Blvd East Suite 350
Rochester Hills, MI 48307
Phone: 248-997-5800 • Fax: 248-218-4072

Acknowledgment of Receipt of Notice of Privacy Information Practices

My signature on this form indicates that I have received a Notice of Privacy Information Practices.

In the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, and who will be able to answer my questions.

Privacy Officer
Sherry Melenovsky
1701 South Blvd East Suite 350
Rochester Hills, MI 48307
(248) 997-5800

I request the following person(s) to receive information regarding my protected health information:

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

You as a patient have the right to:

1. Inspect and copy your medical information that may be used to make decisions about your care.
2. Request an amendment to your medical record if you feel they are incorrect or incomplete. The physician may deny my request and notify me of the reason for her/his denial.
3. Request an accounting of disclosures. This is a list of disclosure for other than treatment, payment or health care operations.
4. Request a restriction or limitation on the medical information used or disclosed about me for treatment, payment or health care operations. All requests must be made in writing. However, the physician has the right to deny the restriction. If she/he does agree to the restriction, the office will comply with your request unless the information is needed to provide you with emergency care.

Print Patient Name _____ Date _____

Signature _____

Office use only: ___ Patient refused to sign consent, despite a good faith efo



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Ivana Vettraino M.D, M.B.A • Nicole Lape P.A-C

Name: _____ Age: _____

Date: _____ E-Mail Address: _____

Birth date: _____ Marital Status: S M W D Separated (Please Circle One)

Who referred you to us? _____

When was the first day of your last menstrual period (MM/DD/YY): _____

How many times have you been pregnant, including this pregnancy? _____

Number of miscarriages: _____ abortions _____ stillbirths _____ tubal pregnancies _____

EDC (due date): _____ Any known allergies? _____

Pharmacy Name & Cross Roads: _____

Reason for consultation: _____

If you have been pregnant before, please fill in the box below and include miscarriage and termination information:

Month/d ate child was born	Delivered at how many weeks?	How long were you in labor?	Vaginal or cesarean delivery? (V or C)	Birth weight of baby	Did you experienc e preterm labor? (Y or NO)	Comments/complications of delivery

For Physician Use: I spent _____ minutes face to face with this patient counseling on the issues detailed in the dictation.

Physician Signature _____

Medical History:

Please check any medical problems you have had. If you answer "yes," please explain in the comments section.

Condition	YES	NO	Comments
Diabetes			
High Blood Pressure			
Heart Disease			
Kidney disease/UTI			
Varicose Veins			
Blood Clots in arms/legs/lungs			
Thyroid Problems			
TB (Tuberculosis)			
Asthma			
Blood Transfusion			
Allergies to medications			
Abnormal pap smear result (s)			
Uterine Anomaly			
Infertility (problems getting pregnant)			
Have you ever received Rhogam?			
Any gynecology (female) problems?			
Any hospitalizations?			

Father of the baby history: _____

Surgical History: _____

Social History:

Do you smoke? Yes/No Amount per day? _____ Amount per day pre-pregnant _____

Do you use alcohol? Yes/No Amount per day? _____ Amount per day pre-pregnant _____

Do you use street drugs? Yes/No Amount per day? _____ Amount per day pre-pregnant _____

Infection History: Please check "yes" or "no" for any of these problems that you might have.

	YES	NO
High Risk for Hepatitis B		
Immunized for Hepatitis B		
Patient or partner with history of genital herpes (please circle which person has history)		
Rash or viral illness since last menstrual period		
Do you live with someone with TB or have you been exposed to TB?		
History of STD: Patient Partner (please circle appropriate answer)		
Gonorrhea, Syphilis, HPV, Chlamydia (please circle appropriate answer)		
OTHER:		

Genetic Information: Please check any of these problems that you, the baby's father or either of your families may have. The heading "FOB" refers to father of the baby.

	Myself	FOB	Family	Unsure
Pregnant at 35 or older				
Thalassemia				
Spina bifida or "open spine"				
Born with a heart problem/condition				
Down syndrome or "Mongoloid"				
Tay-Sachs				
Sickle Cell disease or trait (please circle appropriate condition)				
Hemophilia (bleeding disorder)				
Muscular dystrophy				
Cystic fibrosis				
Huntington chorea				
Mental retardation or "mentally slow"				
Autism or other inherited genetic or chromosomal disorder				
Any other inherited problems				
Diabetic and taking Insulin				
You or the baby's father had a baby with a defect not listed above (please explain)				
Frequent/recurrent pregnancy losses or stillbirth(s)				

Medications: Please tell us of any medications, street drugs or alcohol you have used since your last menstrual period.

Medication(s) / dose: _____

Street Drug(s) / how much: _____

Alcohol / how much: _____

I understand that this is confidential questionnaire and I have answered the above to the best of my knowledge.

Please Print Name _____ Date _____

Signature _____