

Mother-To-Be:

I look forward to our association during this important time in your life. You will have approximately 14 doctor visits during your pregnancy. Typically, your appointments are every 4 weeks until 28 weeks, every 2 weeks until 36 weeks and then weekly until your delivery.

During your initial OB visit you will receive an order for blood work to test for conditions that could be dangerous for the pregnancy if not treated. These labs include: blood type, blood count, rubella and varicella immunity, gonorrhea, chlamydia, hepatitis, syphilis, human immunodeficiency virus (AIDS virus) and other irregular blood antibodies. If due you may also have a pap smear. At each visit a urine specimen will be collected for a urinalysis and urine drug screen. Urinary tract infections are more common during pregnancy. Results are normally discussed at your next scheduled appointment; unless there is an issue that needs to be addressed earlier. These lab results cannot be made available to anyone outside this office without your written consent. This policy is to ensure protection of your privacy.

At 16 weeks of gestational age, you are offered a blood test called Quad Screen. This assesses your risk for having a baby born with birth defects and combines blood values with your medical history to produce the results.

I will also order an ultrasound exam of your infant, routinely performed at approximately 12 weeks and 16-20 weeks gestation. These tests are done to confirm your due date and to look for any abnormalities in your infant. While this is an excellent text, not all abnormalities are detectable with an ultrasound. Ultrasound is also used for medical evaluations when there is bleeding, poor fetal growth, or decreased fetal movement.

At 28 weeks of gestational age, you will receive a lab order for more blood work. This order will include a glucose screen for gestational diabetes. It is recommended to do this fasting to get the most accurate result.

I encourage you to let me know of any questions or concerns you may have throughout your pregnancy. My nurse can answer many of your questions or if necessary she will defer to me for more extensive medical problems.

**Helpful Information**

**Nutritional Recommendations**

* 8-10 glasses of water per day- you have an increased risk for urinary tract infections and kidney stones. Being dehydrated may increase your risk to have preterm contractions.
* Stay active during your pregnancy-walking is an excellent form of exercise.
* Recommended weight gain is 25-30 lbs.
* Not more than 2 servings of caffeine a day, if desired.
* Prenatal Vitamins- over the counter prenatal vitamins are fine to take. I do not recommend vitamins with herbs. If you wish to get a prescription sent to your pharmacy, please inform me at your visit.

**Nausea and Vomiting**

* Try to eat small amounts of food frequently throughout the day.
* Sip liquids constantly- the most important thing is to **stay hydrated.** If vomiting is continuous and you are unable to hold down liquids, call the office.
* Vitamin B6 50 mg 2 or 3 times a day up to 200 mg may be helpful. This is over the counter at your pharmacy.

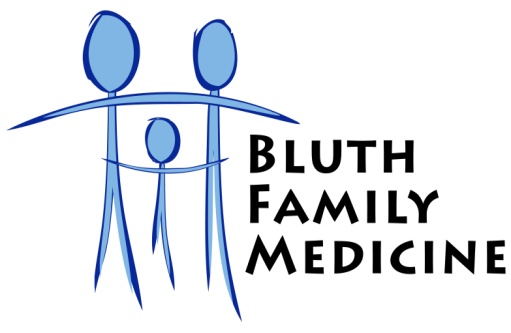
**Approved over the counter medication**

* **All medications have the potential for side effects. Use medication when needed but sparingly**
* Tylenol (extra strength) – use as directed on the bottle **NO ASPIRIN OR IBUPROFEN**
* **Cold medications**- Sudafed, Benadryl, Claritin, Zyrtec
* Tums, Mylanta, Maalox, Prevacid, Zantac, Pepcid
* **Constipation**- Colace and Mira Lax- Increase fiber

**Call the office for the following:**

* **Vaginal Bleeding**
* **Fluid leaking from vagina**
* **Temp over 101**
* **Severe abdominal/pelvic pain**

**\*\*NO ALCOHOL\*\*\*NO DRUGS\*\*\*NO SMOKING\*\*\* NO HOT TUBS OR SAUNAS\*\***



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Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature (Adult) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELEASE FOR MINOR CHILDREN (Under 18)

I, (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent or official guardian of (print child’s name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby grant permission to Bluth Family Medicine representatives, to take and use: photographs and/or digital images of my child for use in news releases and/or educational materials as follows: printed publications or materials, electronic publications, or web sites. I agree that my child’s name and identity: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, and digital reproductions shall be the property of Bluth Family Medicine.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (parent or guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HISTORY QUESTIONNAIRE**

**A.**

**1**. Marital Status: \_\_Single \_\_Married \_\_Long term Relationship \_\_Divorced \_\_Widowed

**2.** Reason for this visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.** Referring Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4**. Occupation: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5.** Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Carrier\_\_\_\_\_\_\_\_\_\_ Voicemails? \_\_Yes \_\_No

**6.** Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None\_\_\_\_ Partner’s Age \_\_\_\_\_

Partner’s Ocupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. MENSTRUAL HISTORY (Complete even if post-menopausal or no longer having periods)**

**7.** Age at first period: \_\_\_\_years

**8.** If your menstrual periods are regular; periods start every \_\_\_\_ days.

**9.** If your menstrual periods are irregular; periods start every \_\_\_ to \_\_\_ days (ex: 12-60)

**10.** Duration of bleeding \_\_\_\_\_days

**11**. Does bleeding or spotting occur between periods? \_\_\_\_Yes \_\_\_\_No

**12**. Does bleeding or spotting occur after intercourse? \_\_\_\_Yes \_\_\_\_ No

**13.** First day of last menstrual period. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14.** Is pain associated with periods? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Occasionally

**15.** If yes to question 14, is it before menses? \_\_\_\_ During menses? \_\_\_\_ Both?\_\_\_\_

**C. PREGNANCY HISTORY (ALL PREGNANCIES) Never been pregnant? \_\_\_\_\_\_\_\_\_**

**16. OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Place of Delivery** | **Duration of Preg.** | **Hours of labor** | **Type of Delivery** | **Complications Mother and/or infant** | **Sex**  **Infant:** | **Birth Weight** | **Present Health** |
|  |  |  |  |  |  |  |  |  |
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**D. BIRTH CONTROL HISTORY**

17. What birth control method(s) do you currently use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E. SEXUAL HISTORY**

**18**. Do you have a sexual partner? \_\_\_\_Yes \_\_\_\_ No (Male \_\_\_\_ Female\_\_\_\_)

**19.** Are there concerns about your sexual activity which you may want to discuss with your doctor? \_\_\_\_\_Yes \_\_\_\_\_No

**F. PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES**

**20. Check any that apply or \_\_\_\_\_\_\_\_None**

**SURGERY YEAR SURGERY YEAR**

**\_\_\_\_**D & C \_\_\_\_\_\_ \_\_\_\_ovarian surgery \_\_\_\_\_\_

\_\_\_\_hysteroscopy \_\_\_\_\_\_ \_\_\_\_L cyst(s) removed ovarian \_\_\_\_\_\_

\_\_\_\_infertility surgery \_\_\_\_\_\_ \_\_\_\_R cyst(s) removed ovarian \_\_\_\_\_\_

\_\_\_\_tuboplasty \_\_\_\_\_\_ \_\_\_\_L ovary removed \_\_\_\_\_\_

\_\_\_\_tubal ligation \_\_\_\_\_\_ \_\_\_\_R ovary removed \_\_\_\_\_\_

\_\_\_\_laparoscopy \_\_\_\_\_\_ \_\_\_\_ vaginal or bladder repair \_\_\_\_\_\_

\_\_\_\_hysterectomy (vaginal) \_\_\_\_\_\_ for prolapsed or incontinence

\_\_\_\_hysterectomy (abdominal) \_\_\_\_\_\_ \_\_\_\_cesarean section \_\_\_\_\_\_

\_\_\_\_myomectomy \_\_\_\_\_\_ \_\_\_\_other(specify)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**G. PAST SURGICAL HISTORY (NOT OB/GYN)**

**21. List all surgeries and their year or \_\_\_\_\_\_\_None**

**SURGERIES YEAR**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**H. PAP SMEAR/MAMMOGRAM HISTORY**

**22.** Date of last pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**23**. Have you had abnormal pap smear? \_\_Yes \_\_No

**24.** Have you had treatment for abnormal smears? \_\_Yes \_\_No

**If yes, what type(s) of treatment have you had?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**25.** Date of last mammogram: Month\_\_\_\_ Year\_\_\_\_

**26.** Have you had an abnormal mammogram? \_\_\_Yes \_\_\_No

**OTHER PAST GYNECOLOGICAL HISTORY**

**27. Check any that apply: \_\_\_\_\_**Venereal warts \_\_\_\_\_Herpes(genital) \_\_\_\_\_Syphilis

\_\_\_\_Pelvic inflammatory disease \_\_\_\_\_Endometriosis \_\_\_\_\_Chlamydia \_\_\_\_\_Gonorrhea

\_\_\_\_Vaginal infections \_\_\_\_\_None Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **PAST MEDICAL HISTORY Check any that apply or**  \_\_\_\_**None**

\_\_\_\_Arthritis \_\_\_\_Kidney disease \_\_\_\_Emphysema

\_\_\_\_Diabetes: \_\_\_\_Gallstones \_\_\_\_Bronchitis

\_\_Diet controlled \_\_\_\_Liver Disease (including hepatitis)

\_\_Pill controlled \_\_\_\_Epilepsy \_\_\_\_HIV+

\_\_Insulin controlled \_\_\_\_Blood Transfusions \_\_\_\_Eating disorder

\_\_\_\_High blood pressure \_\_\_\_Thyroid disease \_\_\_\_Other:

\_\_\_\_Heart disease \_\_\_\_Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**J. CURRENT MEDICATIONS (INCLUDE DOSE (AMOUNT) PER DAY)**

**Medication Dose Frequency**

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| --- | --- | --- |
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**K. DO YOU CURRENTLY?**

**28**. Smoke \_\_\_No\_\_\_ Yes \_\_\_\_Packs a day

**29.** Use alcohol \_\_\_No\_\_\_Yes – Wine(glasses/day) \_\_\_ Beer(bottles/day) \_\_\_\_ Liquor(oz/day)\_\_\_\_

**30.** Use Illicit drugs \_\_\_No \_\_\_Yes – Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily amount \_\_\_\_\_\_\_\_\_\_\_\_\_

**31.** Exercise \_\_\_No \_\_\_Yes- Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**L. DRUG ALLERGIES**

**32. \_\_\_\_No \_\_\_\_Yes If yes, please list.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**M. FAMILY HISTORY**

**\_\_\_**Diabetes \_\_\_Heart Disease \_\_\_Breast Cancer \_\_\_Other

\_\_\_Ovarian Cancer \_\_\_Endometrial Cancer \_\_\_Colon Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If yes to any of the above, please list affected relatives:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_**None of the above

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**N. OTHER SYMPTOMS**

**Have you had recent?**

\_\_\_weight loss \_\_\_hair growth \_\_\_breast discharge

\_\_\_weight gain \_\_\_hair loss \_\_\_none of the above

\_\_\_change in energy \_\_\_change in urinary function \_\_\_Other

\_\_\_ change in exercise tolerance \_\_\_hot flushes/flashing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**O. Fill out this section ONLY if you are pregnant or planning to be pregnant in the near future.**

**Have you or the baby’s father or anyone in your families ever had any of the following?**

**\_\_\_**Down Syndrome (Mongolism)? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Other Chromosomal abnormality? If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Neural tube defect (spina bifida, anencephaly)? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Hemophilia or other coagulation abnormality? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Muscular Dystrophy? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Cystic Fibrosis? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you or the baby’s biological father are **of Jewish ancestry**, have either of you been screened for Tay-Sachs disease?

\_\_\_Mother Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_**Father Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you or the baby’s biological father are **of African ancestry**, have either of you been screened for Sickle cell trait?

\_\_\_Mother Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Father Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you or the baby’s biological father are **of Italian, Greek, or Mediterranean background**, have either of you been tested for B-thalessemia?

\_\_\_Mother Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Father Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you or the baby’s biological father of **Philippine or Southeast Asian ancestry**, have either of you been tested for A-thalessemia?

\_\_\_Mother Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Father Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_