Haugen OB/GYN Medical History: New Patients – OR - Established not seen 3+ Years

PATIENT NAME:_____

TODAY'S DATE: _____

DATE OF BIRTH: _____

Issues you want to discuss with the Doctor or Nurse Practitioner

_____

_____

Medical problems or hospitalizations

1._____
2._____
3._____
4._____
5._____

Previous surgeries or procedures

1._____
2._____
3._____
4._____
5._____

Have you been pregnant before? __yes __no

Total # pregnancies	# Ectopic/tubal
# Living children	# Miscarriages
# Full term births	# Abortions
# Premature births	

Birth details:

Birth date_____ type of delivery_____
Birth date_____ type of delivery_____
Birth date_____ type of delivery_____
Birth date_____ type of delivery_____

Please provide most recent **date and results** of the following:

Mammogram: Date _____ Result _____
Colonoscopy: Date _____ Result _____
Cholesterol : Date _____ Result _____
Bone Density: Date _____ Result _____
Diabetes/Glucose: Date _____ Result _____
TDAP (Tetanus Diphtheria Pertussis): Date: _____

When was your last **pap smear**?_____
What was the result?_____
Have you had an **abnormal** pap smear before? __yes __no
If yes, what testing and/or treatment was done and when?

_____

Medications you are regularly taking, including prescription, over the counter, herbs, dietary supplements, inhalers, topical creams. **Please include the dose.**

_____
_____
_____
_____
_____
_____

Allergies to medications, latex or shellfish? __yes __no
What are you allergic to and what happens when you take it?

_____
_____
_____

Family History (Include any cancers or medical illnesses in immediate family, grandparents, aunts or uncles)

_____
_____
_____

Other physicians you see for medical care:

_____
_____

Your pharmacy name & city or phone number

_____

Menstrual history: First day of last period _____
___regular or ___irregular
How many days apart?_____
Flow: ___light ___moderate ___heavy
# of tampons or pads per 24 hrs _____
How many days does your period last?_____
Cramps/pain: ___mild ___moderate ___severe
Bleeding between periods? __yes __no

OR

Your age at menopause _____
Did/do you take hormone replacement therapy? __ yes __no
If yes, what and when? _____
Do you have __hot flashes __night sweats __vaginal dryness

Birth control method: _____

Any problem with sexual activity? _____

Relationship status:
__married __partnered __engaged __divorced
__dating __single __widowed
Partner is: __male __female ____transgender

Social History:
Occupation_____

Tobacco use ____yes how much? _____
____never
____quit when? _____

Alcohol use __yes __no If yes, how much? _____
Do you think you should cut down on your drinking? __yes __no
Have people annoyed you by criticizing your drinking? __yes __no
Have you felt guilty about your drinking? __yes __no
Do you ever have a drink first thing in the morning? __yes __no

Recreational drug use __yes __no

Wear **seat belt** __yes __no

Do you feel **safe** at home and at work? ___yes ___no

What do you do for **exercise**? _____
How often? _____

Do you have a **Health Care Directive/Living Will**? ___ yes ___ no
If no, would you like information on how to create one? _____

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider BLOOD family members only when completing:

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives**
Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for hereditary cancer (BRCA/Colaris) in the past? YES NO

		COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)	SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	***EXAMPLE: Two or more relatives with a Lynch syndrome cancer; one under age 50***			*Aunt-colon* *Sister-uterine*	*47 yrs* *60 yrs*
Y	N	Have **YOU** been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	Two or more relatives on the same side of the family w/ any of the following, one diagnosed before 50 (**please circle**): *colon, uterine/endometrial, ovarian, stomach, small bowel, pancreas, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	Three or more relatives on the same side of the family w/ any of the following diagnosed at any age (**please circle**): *colon, uterine/endometrial, ovarian, stomach, small bowel, pancreas, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	Family member has a known Lynch syndrome mutation				

		BREAST AND OVARIAN CANCER (HBOC/BRACAnalysis)	SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast cancer at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	Triple Negative breast cancer under age 60 (ER, PR and Her2 negative receptor status)				
Y	N	A family member with a known BRCA mutation				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age):

_____

Patient's signature: _____ **Date:** _____

FOR OFFICE USE ONLY

☐ Patient is appropriate for further risk assessment and/or genetic testing

☐ Information given to patient to review Follow-up appointment scheduled on _____

Patient offered genetic testing: Accepted OR Declined HCP Signature: _____

HIPAA Authorization for Communication of Information

John A. Haugen Associates, P.A. recognizes that patients have a right to privacy. Consequently, our practice and its physicians and staff will not disclose personal healthcare information unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by federal or state law.

☐ Yes, to facilitate the communication of test results and other information I authorize ***John A. Haugen Associates, P.A.*** to leave confidential information and/or test results on my voicemail if unable to reach me directly.

- Phone Number _____

☐ I do NOT authorize ***John A. Haugen Associates, P.A.*** to leave confidential test results and/or messages on my voicemail.

I am aware that this will be in effect until I notify in writing that this no longer is applicable.

_____ _____
Patient Signature Date

_____ _____
Print Name Date of Birth

OPTIONAL – if you would like your spouse/significant other/guardian/or family member to have access to your personal health information

MINORS (patients under the age of 18): Please be aware that parent/guardian are unable to receive information on their minor child without the below consent signed.

I give ***John A. Haugen Associates, P.A.*** permission to release any of my personal health information

to: _____.

I am aware that this will be in effect until I notify in writing that this no longer is applicable.

_____ _____
Patient Signature Date

_____ _____
Patient Name Date of Birth

Haugen OB/GYN

3400 W. 66th Street
Suite 385
Edina, MN 55435
P: 952-927-6561
F: 952-927-6569

801 Nicollet Mall
Suite 400
Minneapolis, MN 55402
P: 612-333-2503
F: 612-333-7575

2805 Campus Dr.
Suite 315
Plymouth, MN 55441
P: 763-577-7460
F: 763-577-7461

Patient Name_____ Maiden Name_____

Date of Birth_____ Phone #1_____ Phone #2_____

Address_____ City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____ Fax#_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____ Fax#_____

C) For the purpose of:

_____Continuity of Care/Transfer of Care (2 years at no charge)

_____Self/Personal Copy

_____Insurance _____Disability

_____Work Comp _____Litigation

Date Range_____ to _____

- ☐ Physicians Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Immunizations
- ☐ Lab/Path Reports
- ☐ Operative/Procedure Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____**Subject to Fees

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)

***PLEASE READ** Fee Information: **Haugen OB/GYN** contracts with DataFile Technologies to copy and provide all medical records requested from our office. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy. We reserve the right to charge the fee schedule as set by the State of Minnesota Statute 144.292. A $15.95 handling fee, $1.21 cents per page and postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records, if applicable. 11/2011/Minnesota