Haugen OB/GYN Prenatal Questionnaire

(place patient label here)

Date of Birth: _____ Age: _____

Marital Status: _____ Name of Partner: _____ Physician: _____

Occupation: _____ Hospital (please circle): Abbott Mother Baby -or- Fairview Southdale

First day of last menstrual period: _____ How often do you get a period? _____
How many days do they last? _____ Flow: ____Heavy ____Moderate ____Light
When did you have a positive pregnancy test?_____ Was it a blood or urine test?_____

Pregnancy Symptoms:

___Nausea ___Vomiting ___Loss of appetite ___Cramping ___Pelvic Pain ___Abdominal Pain
___Breast tenderness ___Vaginal bleeding ___Fatigue ___Lightheaded ___Headache ___ Heartburn
___ Hemorrhoids ___ Back pain ___ Pica (craving or eating a nonfood substance) ___ Vaginal discharge
___Constipation ___Diarrhea ___ Urinary urgency ____ Change of urine color ___ Urinary frequency

Pregnancy History:

Date	Weeks at delivery	Hours of Labor	M/F	Type of Delivery	Complications	Where delivered
1)						
2)						
3)						
4)						
*If more than 4 pregnancies please add on the back of this form at the bottom of the page						

History of miscarriage or abortion? _____

Have you had an ultrasound yet this pregnancy? Y / N
If yes, when, where and why: _____

Have you gained or lost weight so far this pregnancy? _____
How much? _____ Over what period of time? _____

History of any significant illnesses/diseases/hospitalizations? _____

History of any surgical procedures? _____

Family history of any significant illnesses/diseases? _____

When was you last pap smear? _____ What were the results? _____

Have you used any alcohol, tobacco or illicit drugs so far this pregnancy? _____

Are you safe at home &/or work? _____ Do you have a history of domestic violence? _____

What medications (including supplements) have you taken so far this pregnancy? _____
_____

Do you have any other medications you haven't taken yet this pregnancy? _____
_____

Date of last flu shot? _____ Do you have close contact with children on a regular basis? Y / N

Do you have any drug allergies? Y / N If Yes, to what? _____
What was the reaction? _____
Are you on any special diet or dietary restrictions? _____

Do you have any cats in the home? Y / N If Yes, are they ___ Indoor ___Outdoor ___ Both

Do you have any exposure risks at work or home?

___ **No obvious risky exposure**
___ Stay at home mom/caring for own children
___ Chemical/radiation exposure
___ Exposure to lead
___ Extensive travel
___ Heavy lifting
___ High level of stress
___ Work in health care clinic
___ Work in hospital
___ Work with children (school or daycare)
___ Sit for prolonged periods
___ Stand for prolonged periods

Infection/Exposure History:

___ No history of infectious diseases
___ History of STD, GC, Chlamydia, HPV, Syphilis
___ Sexual partner who has had genital herpes
___ Vaccinated or is at risk for Hepatitis B
___ Rash or viral illness since last menstrual period
___ Is at risk for HIV due to IV drug use or partner with HIV
___ Has had a history of genital herpes
___ History of chicken pox or Immunization
___ Lives or has lived with someone with TB

Genetic screening:

Will you be age 35 or older at the time of delivery? _____
Are you of Greek, Mediterranean or Asian background? _____
Is there family history of:

___ Open Neural Tube Defect (Spina Bifida, Anencephaly, Meningomyelocele)
___ Congenital Heart Defect
___ Down's Syndrome
___ Jewish or French Canadian Ancestry
___ Canavan Disease
___ Sickle Cell Disease or trait
___ Hemophilia or other blood disorders
___ Muscular Dystrophy
___ Cystic Fibrosis
___ Huntington's Chorea
___ Mental Retardation or Autism If so, were they tested for Fragile X? _____
___ Other inherited genetic or chromosomal disorders
___ Maternal metabolic disorder (ie. Diabetes or PKU)

Does the father of the baby have any children with birth defects not listed above? _____

If additional pregnancies to list:

Date	Weeks at delivery	Hours of Labor	M/F	Type of Delivery	Complications	Where delivered
5)						
6)						
7)						
8)						
9)						
10)						

Haugen OB/GYN

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

801 Nicollet Mall, Suite 400
Minneapolis, MN 55402
612.333.2503

3400 W. 66th Street, Suite 385
Edina, MN 55435
952.927.6561

2805 Campus Drive, Suite 315
Plymouth, MN 55441
763.577.7460

haugenobgyn.com

Haugen OB/GYN

3400 W. 66th Street
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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