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:** _____

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☐ 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: _____

Haugen OB/GYN

Patient Name: _____ DOB: _____

The State of Minnesota requires that we collect information on race, ethnicity, language, and country of origin. This information is collected to ensure that people of all races and ethnicity receive quality care. Your responses are confidential. If you prefer, you do not need to answer these questions.

With what language do you feel most comfortable communicating?

What is the country of your birth?

What category best describes your ethnicity (cultural background):

- ☐ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or Spanish culture or origin, regardless of race.
- ☐ **Not Hispanic or Latino:** A person not of Hispanic or Latino culture.
- ☐ **Decline to answer**

What category best describes your race:

- ☐ **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **Black or African American:** A person having origins in any of the black racial groups of Africa.
- ☐ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or Spanish culture or origin, regardless of race.
- ☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- ☐ **Some Other Race/Unknown:** A person who does not self-identify with any of the race categories.
- ☐ **Decline to answer**

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Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated.

Patient Name: _____

Date of Birth: _____ **Telephone # ( )** _____

Entity Requested to Release Information: _____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone/Fax: _____ / _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:
- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only)
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only disclose the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____

Patient or Legal Representative Signature Date

_____

If signed by Legal Representative, Print Name and Relationship to Patient Signature of Witness

***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 $18.70 handling fee, $1.41 cents per page and postage will be invoiced to you from DataFile Technologies, LLC with all the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records, if applicable. 03/2019