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)							

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**

Haugen OB/GYN

Patient Authorization for Disclosure of Protected Health Information

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

Patient Name: ______________________________

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

Records to be released FROM: ______________________________

Address: ______________________________

Phone/Fax: ______________________ / ______________________

Records to be released TO: ______________________________

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

***This release can be faxed to Haugen OB/GYN at 952-927-6569. If you have any questions please call 952-927-6561**