

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.

| | |
|---|--|
| <p>With what language do you feel most comfortable communicating?</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>What is the country of your birth?</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <p>What category best describes your race:</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> Black or African American: A person having origins in any of the black racial groups of Africa.</p> <p><input type="checkbox"/> Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or Spanish culture or origin, regardless of race.</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p> <p><input type="checkbox"/> White: A person having origins in any of the original peoples of Europe; the Middle East, or North Africa.</p> <p><input type="checkbox"/> Some Other Race/Unknown: A person who does not self-identify with any of the race categories.</p> <p><input type="checkbox"/> Decline to answer</p> |
| <p>What category best describes your ethnicity (cultural background):</p> <p><input type="checkbox"/> Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or Spanish culture or origin, regardless of race.</p> <p><input type="checkbox"/> Not Hispanic or Latino: A person not of Hispanic or Latino culture.</p> <p><input type="checkbox"/> Decline to answer</p> | |

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 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

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:
- | | |
|---|--|
| <input type="checkbox"/> office notes | <input type="checkbox"/> nursing home, home health, hospice, and other physician records |
| <input type="checkbox"/> lab results, pathology reports | <input type="checkbox"/> record of HIV and communicable disease testing |
| <input type="checkbox"/> x-rays | <input type="checkbox"/> record of mental health or substance abuse treatment |
| <input type="checkbox"/> financial history report (previous 3 years only) | <input type="checkbox"/> 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