

The Women's Clinic of Northern Colorado

Phone (970) 493-7442

1107 S Lemay Ave, Ste 300, Fort Collins • 2500 Rocky Mtn Ave, North MOB, Ste 150, Loveland

Prenatal Questionnaire

Patient Name:

Age:
Address:
Home Phone:
Work Phone:
Cell Phone:
Occupation:
Employer:
Language:
Religion:
Hospital plan to deliver at: PVH or MCR (circle one)

Father of Baby:
Partner Name:
Age:
Address:
Home Phone:
Work Phone:
Occupation:
Employer:
Language:
Religion:

PREVIOUS PREGNANCIES

Year/date Gestation wks Delivery type Hospital Baby's weight Gender Baby Name

- 1. Were any babies born with birth defects? Yes No
2. Did any babies develop jaundice, infections or other problems in first 2 weeks of life? Yes No
3. Did you have diabetes, high blood pressure, bleeding, depression or other problems during a pregnancy? Yes No

CURRENT PREGNANCY

- 1. What was your weight before pregnancy? How tall are you? What was the first day of last normal menstrual period? Was this period (please circle): longer shorter normal? What was the first day of previous menstrual period? Menstrual periods usually occur every days and last days Are menstrual periods usually (please circle): regular irregular? If you have used birth control pills in the past, when did you take the last pill? If you used any other form of birth control, before or since your last period, what was the method?
2. Have you had bleeding or spotting since your last menstrual period? Date: Yes No
3. Have you had any of these symptoms since your last menstrual period? Cramps or abdominal pain Date: Yes No Enlarged or painful breasts Date: Yes No More frequent urination Date: Yes No Fatigue Date: Yes No Nausea and vomiting Date: Yes No Positive pregnancy test Date: Yes No
4. Was this pregnancy unplanned? Yes No
Have you ever tried but couldn't get pregnant for over one year? Yes No
Are you or the baby's father unhappy about this pregnancy? Yes No

5. Systems review:

- Any problems with excessive thirst, weakness, or loss of energy? Yes No
Any problems with excessive bruising or failure of blood to clot with a cut or tooth extraction? Yes No
Any problems with eyes or vision, ears or hearing, nasal congestion or throat problems? Yes No
Any problems with chest pain, prolonged cough or shortness of breath? Yes No
Any problems with swelling of hands or feet? Yes No
Any problems with stomach pain, food intolerance, black or bloody bowel movements, diarrhea or constipation? Yes No
Any problems with discomfort while urinating, getting up at night to urinate, urgency with urination? Yes No
Do you leak urine when you laugh, cough, sneeze or lift? Yes No
Are you having vaginal irritation or excessive vaginal discharge? Yes No
List date and results of last pap smear: _____
Do you bleed between periods or after intercourse, or pain with intercourse or other sexual problems? Yes No
Do you have pain, lumps or fluid leaking from your breasts? Yes No
Any problems with headaches, dizziness, blacking out, numbness or paralysis? Yes No
Do you have loss of appetite, problems getting to sleep, or staying asleep? Yes No
Do you cry without reason, feel anxious or depressed, or have thoughts of suicide? Yes No
Have you ever had professional counseling (psychiatric/psychological)? Yes No
Are problems at home or work bothering you? Yes No
Any pain in the back, muscles, bones or joints? Yes No

6. List any medications you have taken since your last menstrual period.

Are you currently taking prenatal vitamins?

Pharmacy of choice:

7. Please list any problems concerning your pregnancy or general health you would like to discuss:

PAST HISTORY

1. Please circle any illness that you have experienced in the past:

German measles, chicken pox, mumps, rheumatic fever, bladder or kidney infections, hepatitis or jaundice

2. Please circle any problem that you have experienced in the past:

diabetes, thyroid disorders, cancer, allergies to foods or inhaled substances, anemia, failure of blood to clot, heart problems, high blood pressure, phlebitis or blood clots, lung problems, asthma, convulsions, epilepsy, polio, emotional problems, depression, drinking problems, drug problems, disease of the brain, nerves, liver, kidney, intestines, abnormalities of female organs (cervix or uterus).

3. Please list all hospital stays or surgeries:

Year/date/age	Hospital	Physician	Reason for surgery/hosp	Type of surgery	Complications
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4. Please list all allergies to drugs or medications:

6. Do you have any birth defects? Yes No

7. Have you ever had any of the following diseases?

Gonorrhea _____ Date: _____ Yes No

Syphilis	Date: _____	Yes	No
Chlamydia	Date: _____	Yes	No
Herpes	Date: _____	Yes	No
Genital Warts	Date: _____	Yes	No
Have you ever had an abnormal Pap test?	Date: _____	Yes	No
Have you ever had a colposcopy?	Date: _____	Yes	No
Have you ever had a LEEP (Loop Electrode Excision Procedure)?	Date: _____	Yes	No
8. Have you ever had a blood transfusion?		Yes	No
9. Date of last Tetanus? _____			
10. Have you ever had any other significant health problems? Please explain:			

PREGNANCY RISK FACTORS

1. Will you be 35 or older when the baby is born?		Yes	No
2. Do any family members have these conditions that can possibly be inherited?			
Cystic Fibrosis		Yes	No
Down Syndrome (Mongolism)		Yes	No
Muscular Dystrophy		Yes	No
If yes, what type? _____			
Heart attack or stroke before age 45		Yes	No
Hemophilia		Yes	No
Huntington Disease		Yes	No
Hydrocephalus (water on the brain)		Yes	No
Neural Tube Defect (Spina Bifida)		Yes	No
PKU (Phenylketonuria)		Yes	No
Sickle Cell Anemia		Yes	No
Tay-Sachs Disease (Ashkenazi Jews)		Yes	No
Recurring miscarriages (3 or more)		Yes	No
Other: _____		Yes	No
3. Do you smoke cigarettes?		Yes	No
If so, how many per day: _____ Age started smoking? _____			
If you drink alcohol, what type of drinks do you have? _____			
How many drinks per week? _____			
Since your last menstrual period have you used the following drugs:			
Accutane		Yes	No
Streptomycin or Gentamicin		Yes	No
Anti-cancer medicines		Yes	No
Birth control pills		Yes	No
Coumadin (blood thinner)		Yes	No
Dilantin, Depakene or other drugs for epilepsy		Yes	No
Flagyl or Metronidazole		Yes	No
Other Vitamins (more than minimum daily requirements)		Yes	No
Have you or the baby's father taken street drugs such as cocaine, marijuana, amphetamines, LSD, heroin, or Quaaludes, in the three months prior to conception?		Yes	No
Are you or the baby's father currently taking any of the street drugs listed above?		Yes	No
4. Have you been exposed to potentially dangerous chemicals such as Agent Orange, Dioxin, or insecticides?		Yes	No
Have you been exposed to X-Rays since your last menstrual period?		Yes	No
Since your last menstrual period, have you been exposed to German Measles (Rubella) or Chicken Pox (Varicella)?		Yes	No
Do you eat raw meat or change a cat litter box?		Yes	No
Do you suspect that you may have been exposed to the AIDS virus through sexual contact, dirty needles, or blood transfusions?		Yes	No
Do you work in an institution with mentally or physically handicapped?		Yes	No
Do you have children in preschool?		Yes	No
Have you had an illness with fevers since your last menstrual period?		Yes	No
Have you used saunas or hot tubs since your last menstrual period?		Yes	No

5. Are you on a special diet? Yes No
 Are you experiencing significant emotional stress? Yes No
 Do you exercise regularly? Yes No
 Do you wear seat belts? Yes No
 Is your relationship with the baby's father stable and fulfilling? Yes No

FAMILY HISTORY

Are you: (please circle all that apply)
 Caucasian Asian Mediterranean African American Hispanic French Canadian Jewish Other: _____

Is the baby's father: (please circle all that apply)
 Caucasian Asian Mediterranean African American Hispanic French Canadian Jewish Other: _____

Do any of the following conditions exist in your family, in the baby's father, or in his family? Just mark 'yes' or 'no' - we will discuss specific family members at your appointment.

Illness	<u>Anybody in YOUR family?</u>	<u>Baby's father ONLY</u>	<u>Anybody in HIS family?</u>
Birth defects	Yes or No	Yes or No	Yes or No
Mental Retardation	Yes or No	Yes or No	Yes or No
Genetic Disorder	Yes or No	Yes or No	Yes or No
Twins	Yes or No	Yes or No	Yes or No
Fibroids	Yes or No	N/A	Yes or No
Endometriosis	Yes or No	N/A	Yes or No
Diabetes	Yes or No	Yes or No	Yes or No
Anemia	Yes or No	Yes or No	Yes or No
Stroke/blood clots	Yes or No	Yes or No	Yes or No
Heart attack	Yes or No	Yes or No	Yes or No
High Blood pressure	Yes or No	Yes or No	Yes or No
Thyroid problems	Yes or No	Yes or No	Yes or No
Osteoporosis	Yes or No	Yes or No	Yes or No
Bleeding problems	Yes or No	Yes or No	Yes or No
Dementia/Alzheimer's	Yes or No	Yes or No	Yes or No
Ovarian cancer	Yes or No	N/A	Yes or No
Uterine cancer	Yes or No	N/A	Yes or No
Colon cancer	Yes or No	Yes or No	Yes or No
Breast cancer	Yes or No	Yes or No	Yes or No
Other cancer	Yes or No	Yes or No	Yes or No
Drinking or drug problem	Yes or No	Yes or No	Yes or No
Depression	Yes or No	Yes or No	Yes or No

Comments: _____



Consent for the Use or Disclosure of Protected Health Information

I understand that as part of my healthcare, The Women's Clinic of Northern Colorado originates and maintains health records describing my health history, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

I understand that this information serves as:

- A basis for planning my care and treatment, including other healthcare professionals and facilities that contribute care such as pathology and radiology.
- A means for communication among the many healthcare professionals and facilities who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Please indicate with the following choices that you consent to:

H-Home B-Business C-Cellular A-All O-Other

- _____ Messages/phone calls regarding appointments
_____ Messages/phone calls regarding lab/test results
_____ Messages/phone calls regarding financial account information

Please **initial** below giving consent to the following:

- _____ Receive information by mail regarding appointments
_____ Receive information by mail regarding lab/test results
_____ Receive information by mail regarding marketing or promotion material.

- _____ If married, provide medical or financial information to spouse
_____ If a minor, provide medical or financial information to legal guardians

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing a restriction request form. I further understand that The Women's Clinic of Northern Colorado is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing a revocation form and returning it to Medical Records at The Women's Clinic of Northern Colorado. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

By signing this consent, I acknowledge that I have read and understand The Women's Clinic of Northern Colorado Notice of Privacy Practices statement.

Signature

Date

Patient Sticker

Women's Clinic of Northern Colorado
Care Agreement

After hours care:

- Urgent or Emergent care by a WCNC physician or certified nurse midwife is available 24/7 on call.
- After hours care is triaged through our qualified nurse staffed answering service.

Reflex Testing:

Pap tests may reveal that a patient is at risk for the HPV virus. If your test reveals this, WCNC authorizes the pathologist to automatically order the High Risk Strain HPV test. We recommend HPV testing with a Pap smear for all patients 30 years and older. If both tests are normal, you will only need a Pap smear every third year. Tests will be billed to you and your insurance by the pathology provider. If you choose to not allow reflex testing, please inform clinical staff and your provider.

- I Accept I Decline the high-risk HPV testing. _____ Staff initials

Gonorrhea & Chlamydia Testing:

WCNC recommends routine gonorrhea and Chlamydia testing for all women 25 and under. This will be done at the same time as your Pap. If you choose to decline this testing, please inform clinical staff and your provider.

- I Accept I Decline Gonorrhea & Chlamydia testing _____ Staff initials

Medication History:

Electronic prescribing enables access to your medication history for any prescriber, which allows your WCNC provider to prescribe medication for you more effectively. Do you agree to access of your medication history by WCNC staff?

- I Agree I Do Not Agree to access of my medication history by prescribers other than WCNC

Mammograms:

WCNC supports the American Cancer Society (www.cancer.org) guidelines as follows:

Over 20	Breast Self Exam	Monthly	Report changes/symptoms to your health provider
20-39	Clinical Breast Exam	Every year	
40+	Clinical Breast Exam	Every year	
40+	Mammogram	Every year	Or as may be recommended by your provider

Privacy Practices:

I have been offered the opportunity to review, read and understand the WCNC Notice of Privacy Practice.

I hereby consent that my health records may be disclosed to necessary parties for the purposes of my treatment, payment and health care services.

I understand I may revoke my consent at any time; however WCNC is not required to accept my request. Revocation form must be completed and returned to the WCNC to be enforced and in effect the day it is received by WCNC.

Financial Obligations:

I am obliged to understand, agree, and be financially responsible for services rendered to me by WCNC providers.

I agree to pay my balance in full upon receipt of WCNC Statement or letter requesting such payment.

I understand and agree that balances over 30 days old will incur a service charge and be considered past due.

I authorize the release of any information necessary to process my claims and irrevocably assign all benefits for claims to WCNC.

Patient Signature

Date