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:	DOB:	Father of Baby:
Address:		Partner Name:
		Age:
		Address:
Home Phone:		
Work Phone:		Home Phone:
Cell Phone:		Work Phone:
Occupation:		Occupation:
Employer:		Employer:
Language:		Language:
Religion:		Religion:
Hospital where you plan to deliver:	**PVH MCR**	(circle one)

PREVIOUS PREGNANCIES

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

1. Were any babies born with any chromosomal abnormalities?
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?
   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: _____ More: _____ Yes No
   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, have 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, work, or in relationship 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 rheumatic fever bladder or kidney infections hepatitis 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, or 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

4. Please list all allergies to drugs or medications:

		Yes	No
5.	Have you 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
	Have you ever had a blood transfusion?		Yes No
	Date of last Tetanus: _____		
	Have you ever had any other significant health problems? Please explain:		Yes No

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?	Yes No
	Cystic Fibrosis	Yes No
	Down Syndrome	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: _____
Do you smoke marijuana? Yes No
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, 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	Anybody in YOUR family?	Baby's father ONLY	Anybody in HIS family
Chromosomal Abnormalities	Yes or No	Yes or No	Yes or No
Intellectual Disabilities	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	Yes or No	Yes or No
Endometriosis	Yes or No	Yes or No	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	Yes or No	Yes or No
Uterine cancer	Yes or No	Yes or No	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: _____

_____

_____

Women's Clinic of Northern Colorado (WCNC)
Consent for the Use or Disclosure of Protected Health Information (PHI)

I understand that as part of my healthcare, WCNC originates and maintains health records describing my history, exam, tests results, diagnoses, treatments: past present and future; as well as costs, payments and adjustments by myself and my health plan.

I, _____, hereby consent to the use, access and disclosure of my PHI for the purposes of:

- planning my care and treatment, including other professionals and facilities that contribute to my care.
- communicating with other professionals who contribute to my care.
- evaluating care quality and professional competence.
- communicating appointments and/or balances on previously rendered and/or charged services for WCNC provider and our agents and assigns.
- supplying diagnostic and procedural information to a third party for the processing of my services and bills related to my service.

I, _____, **hereby consent to the use, access and disclosure of my PHI to:**

☐ Spouse _____ ☐ Parent/Guardian_____

☐ Son/Daughter_____ ☐ Other_____

*By signing below, I understand and give my full consent to be contacted on the landline and/or cell phone number(s) provided to Women's Clinic of Northern Colorado and their assigns, including: appointments, test results, financial information, billing, and marketing material. This express authorization also applies to any landline or cell phone number(s) that I may acquire in the future. Women's Clinic of Northern Colorado and their assigns may also contact me by sending text messages or emails, using any e-mail address I may provide. *NOTE: Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving services.*

I understand:

- I may request restriction on the uses and disclosures of my **PHI** at any time by completing and signing a restriction request form. I understand that WCNC is not required to accept my restriction request.
- I understand I may revoke this consent at any time by signing a revocation form and returning it to the Medical Records Department at WCNC. I further understand that any such 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.

My signature below acknowledges that I have read and understand and consent to WCNC privacy and disclosure practices.

_____ _____

Signature Date

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:

By accepting this section you agree to have a Pap test that reveals risk for HPV, further tested for the High Risk Strain of HPV. We recommend HPV testing with a Pap smear for all patients between the ages of 30 and 65. If both tests are normal, a Pap smear every five years is recommended. The pathologist will bill you or your insurance. ☐ 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 ☐ N/A _____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

Colorado Prescription Drug Monitoring Program

If you receive a prescription for a "controlled" (Schedule II through V) drug, your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you and may be accessed for limited purposes by specified individuals. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

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. A 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 and letter, phone call, or text message requesting such payment.
I understand and agree that balances over 30 days old will incur a service charge and be considered past due. I understand that should my account become delinquent and turned over to an attorney and/or collection agency, I will be responsible for all costs of collection, legal fees costs, and attorney fees incurred as a result.
I authorize the release of any information necessary to process my claims and irrevocably assign all benefits for claims to WCNC.

_____ _____
Patient Signature Date

Sticker