OAHU OBGYN

Obstetrics and Gynecology

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PRENATAL QUESTIONNAIRE-NOB

DATE: __ __/ __ __/ __ __
(MM/DD/YY)

PATIENT

Name: _____ Date of Birth: __ __/ __ __/ __ __ AGE: _____
(MM/DD/YY)

Name you'd like to be called by: _____ Marital Status: _____

Address: _____
Apt #:

SSN: _____ Email:_____

Home Phone: ( ) _____ _____ Cell Phone: ( ) _____ _____ Work Phone: ( ) _____ _____

Education: _____

Ethnicity: _____

Occupation: _____ Employer: _____

Language: _____

Emergency Contact: _____ Relationship: _____ Cell Phone: ( ) _____ _____

Primary Care Physician: _____ Preferred Pharmacy: _____

FATHER OF BABY

Name: _____ Date of Birth: __ __/ __ __/ __ __
(MM/DD/YY)

Address: _____

Is father of baby your (circle one)…….Husband…….or…….Partner.....?

Home Phone: ( ) _____ _____ Cell Phone: ( ) _____ _____ Work Phone: ( ) _____ _____

Education: _____

Occupation: _____

Employer: _____

PREVIOUS PREGNANCIES

****PLEASE LIST ALL PREGNANCIES INCLUDING MISCARRIAGES, ABORTIONS OR OTHER FAILED PREGNANCIES****

DATE	LENGTH OF PREG (<37WKS?)	HOURS IN LABOR	BABY'S WEIGHT	BABY'S GENDER	TYPE OF DELIVERY		EPIDURAL? (YES/NO)	PLACE OF DELIVERY	COMPLICATIONS/ BABY'S NAME
					VAGINAL	C-SECTION			

PERSONAL MEDICAL HISTORY

Major Illnesses	Yes		Yes		Yes
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI disease		Hepatitis		Seizures	
GI Reflux disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting problem	
Cancer (Breast/Ovary/Uterus/Colon/Etc.):					
Other:					
Father of the baby's Personal Medical History: _____ _____					

FAMILY HISTORY

***** Please indicate relationship associated: mother, father or maternal/paternal grandmother/grandfather, etc. *****

Major Illnesses	**If yes, who?**		**If yes, who?**		**If yes, who?**
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI disease		Hepatitis		Seizures	
GI Reflux disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting problem	
Family History of Cancer (Breast/Ovary/Uterus/Colon/Etc.):					
Other:					

Menstrual History

Age at first period: _____ Number of days of flow: _____ days

Are your periods regular (every 28-30 days)? ____ yes ____ no If not, how often? _____ days

Number of pads ___ or tampons ___ used on heaviest day?

Menstrual flow (please check one): ☐ very light ☐light ☐ moderate ☐ heavy ☐ occasionally heavy ☐ variable

Are your periods painful (cramps)? ___ yes ___ no

How do you treat your pain? _____

When was the first day of your last menstrual period? __ __/ __ __/ __ __ (MM/DD/YY)

If menopausal, how old were you when it occurred? _____

Are you taking hormones? ___ yes ___ no

If so, what type and dosage? _____

Gynecological History

Have you ever been treated for: ☐ Herpes ☐ Chlamydia ☐ Gonorrhea

☐ Genital Warts ☐ Bacterial Vaginitis ☐ Trichomonas ☐ Syphilis

Have you had a Pap smear in the last 7 years? ☐ No ☐ Yes When? _____

Have you ever had an abnormal Pap smear? ☐ No ☐ Yes When?_____

What Abnormality? _____

If over age 35, have you had a mammogram? ☐ No ☐ Yes If so, when? __/__/__ where? _____

If over age 50, have you had a bone density scan done? ☐ No ☐ Yes If so, when? __/__/__ where? _____

Are you currently sexually active? ☐ No ☐ Yes ☐ Never

Did you begin sexual activity before 16 y.o.? ☐ No ☐ Yes If yes, Age started: ____

Have you had > 5 sexual partners in your lifetime? ☐ No ☐ Yes

Sexual Orientation: Heterosexual / Lesbian / Bi-Sexual / _____

Are you currently using birth control? ☐ No ☐ Yes ☐ Trying to get pregnant

Current birth control method used: _____

Are you satisfied with it? ☐ No ☐ Yes

Past birth control methods:

☐ Condoms ☐ Birth control pills ☐ Withdrawal ☐ Tubal Ligation

☐ Diaphragm ☐ Patch ☐ Rhythm ☐ Vasectomy

☐ Vaginal Film ☐ Vaginal Ring ☐ IUD ☐ Essure

Have you ever tested positive for HIV? ☐ No ☐Yes

Did your mother take the drug DES when she was pregnant with you? ☐ No ☐Yes

If your life depended on it, would a blood transfusion be acceptable? ☐No ☐ Yes

Any history of blood transfusion? _____

SOCIAL HISTORY

PERSONAL PROFILE

Birth Place:_____ Ethnicity:_____ Religion:_____

School Completed: ☐ High School ☐ College ☐ Graduate Degree ☐ Other

Exercise: ☐ Yes ☐ No How often_____

Type: _____

Special Diet ☐ Yes ☐ No Type_____

Hobbies, Interests, Goals: _____

HABITS

Smoking ☐ Yes ☐ No Packs/day_____ Years_____ Quit when:_____

Alcohol ☐ Yes ☐ No Drinks/day_____ Drinks/week_____ Quit when:_____

Drug Use ☐ Yes ☐ No Type_____ Years_____ Quit when:_____

Caffeine ☐ Yes ☐ No Cups per day_____ Cups per week_____

Street Drugs ☐ Yes ☐ No If so, what did you use? _____

Do you use seatbelts? ☐ Yes ☐ No Do you use sunscreen? ☐ Yes ☐ No

Do you own guns in your home? ☐ Yes ☐ No If yes, is it in a secure location? ☐ Yes ☐ No

PERSONAL SAFETY

☐ Yes ☐ No Has anyone close to you ever threatened to hurt you?

☐ Yes ☐ No Has anyone ever hit, kicked, choked or hurt you physically?

☐ Yes ☐ No Has anyone, including you partner, every forced you to have sex?

☐ Yes ☐ No Are you ever afraid of your partner?

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, hypertension, bleeding, depression or other problems during a pregnancy YES NO
4. Have you/ baby's father had a child that died around the time of delivery or in the first year of life? YES NO

CURRENT PREGNANCIES

1. What was your weight before pregnancy? _____ lbs.

2. What is the first day of your last normal menstrual period? __ __/ __ __/ __ __ (MM/DD/YY)
3. Was this period ☐ longer or ☐ shorter than usual or ☐ normal?
4. Menstrual periods usually occur every _____ days and last _____ days
5. Are menstrual periods usually ☐ regular ☐ irregular
6. If you have used birth control pills in the past, when did you take the last pill? __ __/__ __/__ __ (MM/DD/YY)
   If you used any other form of birth control before or since your last period, what was the method?
   _____

7. Have you had bleeding or spotting since your last menstrual period? ……. YES NO
8. Have you had any of these symptoms since your last menstrual period?
   - Cramps or abdominal pain …… YES NO
   - Enlarged or painful breasts …… YES NO
   - More frequent urination ……... YES NO
   - Fatigue ……YES NO
   - Nausea and vomiting ……... YES NO
   - Positive pregnancy test (please write date of first positive result: __ __/ __ __/ __ __ (MM/DD/YY))
9. Was this pregnancy unplanned? ……..YES NO
10. Have you ever tried but couldn't get pregnant for over one year? ……..YES NO
11. Are you or the baby's father unhappy about this pregnancy? ……. YES NO
12. 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 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 result of last pap smear: _____
    - Do you have bleeding between periods or after intercourse, 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, feeling anxious or depressed, crying without reason, 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 back muscles, bones or joints? ……YES NO
13. In the past 6 months have you traveled to Africa, Southeast Asia, the Pacific Islands, South America, Caribbean or areas where Zika virus are exposed?……YES NO
14. List any medications or drugs you have taken since your last menstrual period:
    _____
    _____
15. Please list any problems concerning your pregnancy or general health you would like to discuss:
    _____
    _____

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? ……...YES NO
   - Cystic fibrosis ……YES NO
   - Down Syndrome …….. ……..YES NO
   - Muscular dystrophy ……YES NO
   - Heart attack or stroke before age 45 ……YES NO
   - Hemophilia ……..YES NO
   - Huntington's disease ……..YES NO
   - Hydrocephalus ……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
   - Thalassemia (Anemia) (Mediterranean area) ……..YES NO
   - Recurring Miscarriages ……...YES NO
   - Other: _____
3. Are you and the baby's father related to each other (cousins or otherwise)? …… YES NO
4. Do you smoke cigarettes/ cigars/ pipes? ……...YES NO
   - If yes, how many per day? _____ Age started smoking: _____
5. If you drink alcohol, what type of drinks do you have? _____
   - How many drinks per week: _____
6. 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, depakote or other drugs for epilepsy ……YES NO
   - Flagyl or metronidazole ……...YES NO
   - Other vitamins (more than minimum daily requirements) ……..YES NO

Please circle what applies

7. Have you or the baby's father taken street drugs such as cocaine, marijuana, amphetamines, LSD, heroin or Quaaludes? …… ……..…...YES NO
8. Have you been exposed to potentially dangerous chemicals (i.e. insecticides?) ……YES NO
9. Have you been exposed to x-rays since your last menstrual period? ……YES NO
10. Since your last menstrual period, have you been exposed to German measles (rubella) or chicken pox? ……YES NO
11. Within the last year, have you been hit, slapped, kicked or in some way physically hurt by someone? ……YES NO
12. Since you have been pregnant, have you been hit, slapped, kicked or in some way physically hurt by someone? ……...YES NO
13. In this last year, has anyone forced you to have sexual activities? ……YES NO
14. Do you eat raw meat or change a cat litter box? ……YES NO
15. Do you suspect that you may have been exposed to the HIV virus through sexual contact, dirty needles or blood transfusions? ……YES NO
16. Have you had illness with fevers since your last menstrual period? ……..YES NO
17. Have you used saunas or hot tubs since your last menstrual period? ……....YES NO
18. Are you on a special diet (i.e. vegetarian, etc)? ……YES NO
19. Are you experiencing significant emotional stress? ……....YES NO
20. Do you exercise regularly? ……YES NO
21. Do you use seatbelts regularly? ……YES NO
22. Is your relationship with the baby's father stable and fulfilling? ……..YES NO

PAST HISTORY

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

☐ GERMAN MEASLES ☐ CHICKEN POX ☐ MUMPS ☐ RHEUMATIC FEVER
☐ BLADDER OR KIDNEY INFECTION
☐ HEPATITIS OR JAUNDICE

2. Immunizations (with approximate dates of immunizations):

☐ CHICKEN POX ☐ HEPATITIS B ☐ PERTUSIS

3. Have you had any of the following problems? (Please check all that apply)

☐ DIABETES ☐ THYROID DISORDERS ☐ ALLERGIES TO FOODS OR INHALED SUBSTANCES
☐ ANEMIA ☐ FAILURE OF BLOOD TO CLOT ☐ CANCER
☐ HEART PROBLEMS ☐ HIGH BLOOD PRESSURE ☐ PHLEBITIS OR BLOOD CLOTS
☐ LUNG PROBLEMS ☐ ASTHMA
☐ CONVULSIONS OR EPILEPSY ☐ POLIO
☐ DISEASE OF LIVER OR INTESTINES ☐ KIDNEY DISEASES
☐ ABNORMALITIES OF THE FEMALE ORGANS (CERVIX OR UTERUS)
☐ EMOTIONAL PROBLEM ☐ DEPRESSION ☐ DRINKING PROBLEMS

4. Please list all hospital stays or surgeries:

DATE	HOSPITAL	PROBLEM	SURGERY	OUTCOME OR COMPLICATIONS

5. Please list all allergies to drugs, food or medications:

WHAT ARE YOU ALLERGIC TO	DATE OF MOST RECENT REACTION	WHAT KIND OF REACTION

Latex Allergy: NO YES Reaction: _____

6. Please list all medications (including supplements) you take regularly:

NAME OF MEDICATION	SIZE OR DOSE	HOW OFTEN?	DATE STARTED	REASON

1.Have you ever had the following diseases? (If yes, please circle below) ……...YES NO
- Gonorrhea
- Syphilis
- Chlamydia
- Herpes
- Genital warts

2.Have you ever had an abnormal pap smear? ..... YES NO
3.Do you have any birth defects? …… YES NO
4.Have you ever had a blood transfusion? ……. YES NO
5.Have you ever had any other significant health problems? Please explain:

_____

_____

YOUR FAMILY HISTORY
(Please circle what applies and indicate relationship)

1. Birth defects..... YES NO
2. Heart problems, high blood pressure, strokes…….. CIRCLE ALL THAT APPLY
3. Diabetes, thyroid problems…….. CIRCLE ALL THAT APPLY
4. Anemia or failure of blood to clot …….. CIRCLE ALL THAT APPLY
5. Twins or other multiple births..... YES NO
6. Emotional problems or problems with alcohol or drugs..... CIRCLE ALL THAT APPLY
7. Inherited diseases: _____

Additional comments:

_____

_____

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

INSURANCE AUTHORIZATION AND ASSIGNMENT & CONSENT FOR RELEASE OF INFORMATION

PLEASE READ AND SIGN

I hereby authorize Lynette W. Tsai, MD, Inc. to furnish information to insurance carriers concerning my illness and treatments. I also authorize Dr. Tsai to furnish necessary information regarding my health to other physicians participating in my care if they request it. If I do not desire to release such information, I will inform Dr. Tsai in writing. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. **I understand that I am responsible for any amount not covered by my insurance (i.e. MY DEDUCTIBLE).** I also understand there is a $25-$50 fee for release of medical records. Unless extenuating circumstances apply, I agree to cancel or reschedule my appointment within 24 hours. I understand that I will be responsible for a $50.00 fee for any missed appointment. All fees are subject to change.

Please note that if a letter is requested from Oahu OBGYN, that is NOT considered to be a medical necessity, there will be a $20.00 administrative fee. We will also require a minimum of 3 days' notice for this request.

Patient Signature: _____ Date: __ __/ __ __/ __ __ (MM/DD/YY)

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I acknowledge that by adding or switching to QUEST insurance may result in termination of care with Oahu OBGYN. I understand I will be held responsible for any outstanding balance accrued and establish OBGYN care with a new provider.

Print Name_____ **Birthdate**____/_____/_____

Signature_____ **Date**____/_____/_____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPPA, requires that our office has your consent prior to our healthcare professional discussing your personal health with your family members or significant others.

*Can our Providers discuss your healthcare with any of your family members? YES / NO (please ***circle***)

*Name	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

*What kind of health information do you authorize Oahu OB/GYN to disclose to the designated person(s)?

____ All – at my Provider's discretion	_____ Tests ordered	_____Test Results
____ Date of Treatment	_____ Diagnosis	_____ Treatment Options
____ Treatment Plan	_____Medical History	___Other_____

This authorization will be in effect until such time you request its revision. You have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization.

You do not have to complete this authorization in order to receive treatment from Oahu OB/GYN.

Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

*_____ * ____/_____/_____

Signature Date

*_____ * _____/_____/_____

Print Name BIRTHDATE

* E-mail: _____@_____.____

HIV CONSENT FORM

By signing below, I am giving informed consent for the HIV (Human Immunodeficiency Virus) test based on a full explanation of the test and its ramifications, including the following:

1. Informed consent is required to determine the presence or absence of antibody to or other evidence of HIV*
2. The tests for HIV are VOLUNTARY.
3. The HIV Antibody (841) test is not diagnostic for AIDS. Although most patient with AIDS or the AIDS-Related Complex have antibody to HIV, absence of the antibody does not rule out infection with HIV.
4. Persons with the antibody may not have AIDS. Repeatly reactive antibody screening tests, when not confirmed by Western Blot, may be evidence of prior exposure to the HIV virus of could be false positive tests due to the limitations of the screening procedure.

_____ _____

Patient Signature Date

*Other tests for HIV which require a consent form:

HIV p24 Antigen (838)
HIV Western Blot (840)
HIV Culture (837)
HIV DNA by PCR (765)

A consent form is not needed for HTLV-I (455), which is a completely different virus associated with a form of leukemia.