Dubuque Obstetrics & Gynecology, P.C.

Delhi Medical Center, 1500 Delhi Street, Suite 3100
Dubuque, Iowa 52001
563-557-5959

INITIAL MEDICAL HISTORY

For appointment on _____________; ___________,_____ at _______ am / pm with:
(day) (date) (time)

☐ Eckhart ☐ Anderson ☐ LaBeau ☐ Witthoeft ☐ Page ☐ Janecek ☐ Leppellere ☐ Fautsch

MEDICAL HISTORY

Please list any past or current medical conditions:

Date	Diagnosis	Date	Diagnosis

Have you ever received a blood transfusion? ☐ Yes ☐ No ____________________
Have you ever had MRSA, VRE or GISA? ☐ Yes ☐ No ____________________

PAST SURGICAL HISTORY

If you have ever had surgery, please list the types and approximate dates:

Date	Operation	Anesthesia	Any Complications?

MEDICATIONS

Please list all the prescription drugs you currently take:

Medication	Dose	Medication	Dose

ALLERGIES

Do you have any drug allergies? ☐ Yes ☐ No ________________________
Do you have any food allergies? ☐ Yes ☐ No ________________________
Do you have any environmental allergy? ☐ Yes ☐ No ________________________
Do you have any latex allergies? ☐ Yes ☐ No ________________________

Patient Name: ______________________________

FAMILY MEDICAL HISTORY

Adopted ☐ Yes ☐ No Family History Available ☐ Yes ☐ No
Anesthetic Complications ☐ Yes ☐ No Relationship:______________________________
Breast Cancer ☐ Yes ☐ No Relationship:______________________________
Heart Disease ☐ Yes ☐ No Relationship:______________________________
Colon Cancer ☐ Yes ☐ No Relationship:______________________________
Diabetes ☐ Yes ☐ No Relationship:______________________________
Heart Attack/Chest Pain ☐ Yes ☐ No Relationship:______________________________
Ovarian Cancer ☐ Yes ☐ No Relationship:______________________________
Uterine Cancer ☐ Yes ☐ No Relationship:______________________________
Prostate Cancer ☐ Yes ☐ No Relationship:______________________________
Stroke ☐ Yes ☐ No Relationship:______________________________
Thyroid Disease ☐ Yes ☐ No Relationship:______________________________
Other ☐ Yes ☐ No Relationship:______________________________

MENSTRUAL HISTORY

Age periods began: __________ Frequency of periods: __________ days
Length of period: __________ days Flow: ☐ Light ☐ Medium ☐ Heavy
Number of tampons: __________ Number of pads: __________
Date of last period: __________ Clotting with your period? ☐ Yes ☐ No
Menopausal ☐ Yes ☐ No If yes, age of menopause: __________
Method of birth control: ☐ None ☐ Condoms ☐ Depo Provera
☐ Diaphragm ☐ Essure ☐ Implanon/Nexplanon
☐ IUD ☐ Pill ☐ Tubal Ligation
☐ Vasectomy ☐ Withdrawal ☐ Other ____________
Breakthrough bleeding? ☐ Yes ☐ No Are you on hormone replacement therapy ☐ Yes ☐ No

PREGNANCY HISTORY

#	Date	Weeks Pregnant	Hours Labor	Baby Weight	Sex	Type of Delivery	Anesthesia	Early Labor	Complications/ Comments	Location
1										
2										
3										
4										
5										

GYNECOLOGIC HISTORY

Date of last Pap smear: ________
Have you ever had an abnormal pap smear? ☐ Yes ☐ No If yes, when? ______________________
How was the abnormal pap treated? ☐ Colposcopy ☐ LEEP ☐ Cone ☐ Cryotherapy
Have you ever had a mammogram? ☐ Yes ☐ No Date of last mammogram:______________
Have you ever had breast problems? ☐ Yes ☐ No Describe: ___________________________
Please check the box if you have ever had: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HIV
☐ Trichomonas ☐ Syphilis ☐ Venereal Warts

Patient Name: ____________________________

SOCIAL HISTORY

Tobacco Use? ☐ Yes ☐ No If yes, _____packs/day Age started? __________

If no, have you ever smoked? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, ______ drinks/day, or ____ drinks/wk

Do you use street drugs? ☐ Yes ☐ No If yes, please list: ____________________________

Education: ☐ K-12 Student ☐ Did Not Graduate High School

☐ High School Grad ☐ GED ☐ College Current Student

☐ 2-year degree ☐ 4-year degree ☐ Post Graduate Degree

Occupation: ____

Do you have a new sexual partner? ☐ Yes ☐ No ______________________________

Do you have multiple sexual partners? ☐ Yes ☐ No ______________________________

Do you exercise? ☐ Yes ☐ No ______________________________

Do you feel safe in your home? ☐ Yes ☐ No ______________________________

What is your marital status? ☐ Dating ☐ Divorced ☐ Engaged ☐ Married

☐ Separated ☐ Single ☐ Widowed

SYSTEM REVIEW

Please check if any of the following apply to you TODAY:

Constitutional
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Fever
- ☐ Fatigue

Eyes
- ☐ Double vision
- ☐ Vision changes
- ☐ Wear corrective lenses/glasses

HENT/Mouth
- ☐ Ear aches
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Mouth sores

Breast
- ☐ Pain in breast
- ☐ Discharge
- ☐ Lumps

Cardiovascular/Vascular
- ☐ Chest pain
- ☐ Swelling of legs
- ☐ Palpitations of heart
- ☐ Rapid, irregular heart beats

Respiratory
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Cough, chronic

Gastrointestinal
- ☐ Diarrhea, frequent
- ☐ Bloody stools
- ☐ Heartburn
- ☐ Nausea, vomiting
- ☐ Constipation
- ☐ Hemorrhoids

Urinary
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Urgency
- ☐ Frequency of urination
- ☐ Incomplete emptying
- ☐ Leaky bladder

Skin / Integumentary
- ☐ Rash
- ☐ Ulcers
- ☐ Mole changes

Neurological
- ☐ Dizziness
- ☐ Numbness/weakness
- ☐ Headaches
- ☐ Trouble walking

Musculoskeletal
- ☐ Muscle weakness
- ☐ Joint pain

Endocrine
- ☐ Thyroid disease
- ☐ Hair loss
- ☐ Hot flashes

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Loss of appetite

Hematologic / Lymphatic
- ☐ Bruises, frequent
- ☐ Cuts do not stop bleeding
- ☐ Enlarged lymph nodes

Patient Name: ______________________________