Dubuque Obstetrics & Gynecology, P.C.
Delhi Medical Center, 1500 Delhi Street, Suite 3100
Dubuque, Iowa 52001
563-557-5959

INITIAL MEDICAL HISTORY

Please bring your most current insurance card

For appointment on ______________; ____________,_____ arrive ______ for a ________am / pm with:
(day) (date) (time) (time)
Eckhart Anderson Witthoeft Page Leppellere Hirsch

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

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time of my scheduled appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

Patient Name: ______________________________