Dubuque Ob Gyn

Name_____ Date of Birth_____ Current Date_____

Primary Care Provider: _____

Medication	Dose	Treats	Medication	Dose	Treats

Medical History

Diagnosis	Date	Diagnosis	Date

Surgical History

Surgery	Date	Anesthesia	Complications?

Allergies ☐ No known drug allergies

Item/Medication	Reaction

Social History

Tobacco Use? ☐ Never ☐ Current Smoker ☐ Previous smoker Age started_____ Packs/day_____ Years smoked_____

Do you drink Caffeine? ☐ No ☐ Yes, #_____ day Alcohol Use? ☐ None ☐ Yes, # _____week

Recreational Drug Use? ☐ None ☐ Yes, _____

Exercise? ☐ No ☐ Yes, type _____ How Often?_____

Education: ☐ K-12 ☐ Diploma/GED ☐ College student ☐ Some College ☐ 2-yr degree ☐ 4-yr degree ☐ post-grad degree

Occupation:_____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Legally Separated

Preventative Screenings

Mammogram? ☐ No ☐ Yes, date_____ Bone Density scan? ☐ No ☐ Yes, date_____

Colonoscopy? ☐ No ☐ Yes, date_____ Cholesterol checked? ☐ No ☐ Yes, date_____

Influenza vaccine? ☐ No ☐ Yes, date_____ Tdap? ☐ No ☐ Yes, date_____

Pneumonia vaccine? ☐ No ☐ Yes, date_____ COVID Vaccine? ☐ No ☐ Yes, date_____

Shingles Vaccine Series of 2? ☐ No ☐ Yes, date_____ Gardasil Series of 3? ☐ No ☐ Yes, date_____

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Over the past two weeks, please answer how often you have been bothered by the following problems?

1. Little interest or pleasure in doing things?
   Not at all (0) Several Days (1) More than half of the days (2) Nearly every day (3)
2. Feeling down, depressed, or hopeless?
   Not at all (0) Several Days (1) More than half of the days (2) Nearly every day (3)

Confidential Abuse Questionnaire

Do you feel safe in your home? ☐ Yes ☐ No Are you afraid of your partner or someone else? ☐ Yes ☐ No

Within the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? ☐ Yes ☐ No

If you answered "yes" to any of the above questions, you may be in an abusive situation, and we would like to help. Please indicate how we should contact you or please call the Iowa Domestic Abuse Hotline 1-800-942-0333.

Patients over 65 years of age:

Have you had 2 or more falls in the past year? ☐ Yes ☐ No Had an injury due to a fall in the past year? ☐ Yes ☐ No

Pregnancy History

Pregnancies_____ # Full Term_____ # Premature_____ # Miscarriages_____ # Induced Abortions_____

Living Children_____ # Elective Abortions_____ # Ectopic Pregnancies_____ # Adopted Children_____

Pregnancy History - List in Chronological Order								
Baby's Name	Date of Birth	Weeks Pregnant	Hours in Labor	Birth Weight	Baby's Sex	Type of Delivery	Pain Medication	Complications

Gynecological History

Birth Control Used: ☐ Pills ☐ Condoms ☐ IUD ☐ Tubal Ligation ☐ Vasectomy ☐ Nexplanon ☐ Depo ☐ Other_____ ☐ None

Are you satisfied with your current birth control method? ☐ Yes ☐ No Do you have breakthrough bleeding? ☐ Yes ☐ No

1st Day of Last Period_____ Length of Period _____days Regular ☐ Yes ☐ No Flow ☐ Light ☐ Medium ☐ Heavy

# of pads/tampons_____ /day Clots ☐ No ☐ Yes, size_____ Bloating ☐ No ☐ Yes Cramps ☐ No ☐ Mild ☐ Moderate ☐ Severe

☐ Hysterectomy ☐ Postmenopausal, age at menopause_____ Are you on hormone replacement therapy ☐ No ☐ Yes

Hot Flashes ☐ Yes ☐ No treatment _____

Date of last pap smear, if not done at our office_____ Have you had an abnormal pap? ☐ Yes ☐ No Date_____

Have you had a Colposcopy or LEEP? ☐ Yes ☐ No Have you had: ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Trichomonas

Are you sexually active? ☐ No ☐ Yes, men ☐ Yes, women ☐ Yes, both men and women ☐ Multiple partners ☐ New partner

Experiencing pain with intercourse? ☐ Yes ☐ No Vaginal discharge? ☐ Yes ☐ No

Urinary problems? ☐ No ☐ Yes, _____

Experiencing breast problems? ☐ Yes ☐ No Performing monthly breast exams? ☐ Yes ☐ No Nipple Discharge? ☐ No ☐ Yes

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Past Medical and Family History			
X if you/your family has any of the following:	Personal	Family	Description
Breast Cancer / Breast Disorder			
Heart Disease / Heart Attack / Chest Pain			
High Blood Pressure			
High Cholesterol			
Colon Cancer			
Bowel Disease			
Diabetes			
Ovarian Cancer			
Uterine Cancer			
Prostate Cancer			
Thyroid Disease			
Other			
Headaches / Migraines			
Stroke			
Epilepsy / Neurological Disorder			
Jaundice / Hepatitis			
Hiatal Hernia			
Peptic Ulcer			
Kidney Disease / Stones / Infection			
Urinary Incontinence			
Urinary Infections			
Blood Transfusions			
Anemia			
Blood Clots / Bleeding Disorder			
Skin Disease			
Lung / Respiratory Disease			
Arthritis / Joint Pain			
Osteoporosis			
Anxiety / Depression			
Anesthetic Complications			
MRSA			
VRE			
GISA			
Blood Transfusions			

Review of Systems					
Please check if you are experiencing any of the following today:					
Constitutional	Yes	No	**Urinary**	Yes	No
Unexplained Weight Loss			Blood in Urine		
Unexplained Weight Gain			Pain with Urinating		
Fever			Urgency		
Fatigue			Urinary Frequency		
Eyes			Incomplete Emptying		
Double Vision			Leaky Bladder		
Vision Changes			**Skin**		
Wears Corrective Lenses, Glasses			Rash		
HENT			Ulcers		
Ear Aches			Mole Changes		
Ringing in the Ears			**Neurological**		
Sinus Problems			Dizziness		
Sore Throat			Numbness / Weakness		
Mouth Sores			Headaches		
Breast			Trouble Walking		
Pain in Breast			**Musculosketetal**		
Discharge			Muscle Weakness		
Lumps			Joint Pain		
Cardiovascular			**Endocrine**		
Chest Pain			Hair Loss		
Swelling of Legs			Hot Flashes		
Palpitations of Heart			**Psychiatric**		
Rapid and Irregular Heart Beat			Depression		
Respiratory			Anxiety		
Wheezing			Loss of Appetite		
Coughing Blood			**Heme / Lymp**		
Shortness of Breath			Frequent Bruising		
Cough, Chronic			Cuts Do Not Stop Bleeding		
Gastrointestinal			Enlarged Lymph Nodes		
Frequent Diarrhea					
Bloody Stools					
Heart Burn					
Nausea and Vomiting					
Constipation					
Hemorrhoids					