Siouxland WOMEN'S Health Care P.C.
For every stage of a woman's life.

Patient Name: _____ Today's Date: _____

Address: _____ Age: _____

_____ Date of Birth: _____

Reason for seeing doctor today: _____

Do you have an Advanced Directive / Living Will? ☐ Yes ☐ No Family Doctor: _____

☐ No Known Allergies ☐ Latex Allergy Allergies (Please List Allergy and Reaction) _____

_____

CURRENT MEDICATIONS: List any medications you are taking at this time. Include aspirin, vitamins, laxatives, calcium or herbal supplements, etc.

Current Pharmacy: _____

Name of Drug	Dose (mg, IU, etc.)	Times Taken per Day	Taken For
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

HOSPITALIZATIONS / SURGERIES: (Not for Pregnancies):

Date	Illness or Operation	Complication Yes	Complication No	Hospital/Surgeon
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

PREGNANCY HISTORY: Include all abortions, miscarriages & stillbirths

Number of Pregnancies:	Number of Abortions:	Number of Miscarriages:
Number Of Premature Births (<37 WEEKS):	Number of Live Births:	Number of Living Children:

Pregnancy	Deliver date (mm/dd/yyyy)	Weeks Pregnant	Birth Weight	Vaginal	C-Section	Sex of Child Male	Sex of Child Female	Complication/Hospital/Provider
1				☐	☐	☐	☐	
2				☐	☐	☐	☐	
3				☐	☐	☐	☐	
4				☐	☐	☐	☐	
5				☐	☐	☐	☐	
6				☐	☐	☐	☐	
7				☐	☐	☐	☐	
8				☐	☐	☐	☐	
9				☐	☐	☐	☐	
10				☐	☐	☐	☐	

Pregnancy Complications: Diabetes ☐ Hypertension/High Blood Pressure ☐ Preeclampsia/Toxemia ☐ Preterm Labor ☐

Any history of depression before or after pregnancy? No ☐ Yes ☐ If Yes, how were you treated: _____

Patient Name: _____ Birth Date: _____

PERSONAL HISTORY

Menstrual History

Age at first period: _____

Date of first day of last period: _____

Days between periods (1st day to 1 day): _____

Number of days bleeding with periods: _____

Birth Control Method: _____

	Yes	No
Do you have abnormal periods?	☐	☐
Do you have pain with your periods?	☐	☐
Do you bleed between periods?	☐	☐
Do you have bleeding after sexual intercourse?	☐	☐
Do you have pain with intercourse?	☐	☐

Have you ever had sex?: ☐ Yes ☐ No

Partners Are: ☐ Men ☐ Women ☐ Both

Are you Sexually Active?: ☐ Yes ☐ No

Number of Partners (Lifetime): _____

Have you ever received the pneumococcal vaccine?_____ Date:_____ Facility/Clinic where received: _____

When is the last flu vaccine that you received? _____ Date:_____ Facility/Clinic where received: _____

Marital Status: ☐ Never married ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do you smoke or chew tobacco?: ☐ Yes ☐ No ☐ Quit If Yes, how much?:_____ • How long? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit • I usually drink: ☐ beer ☐ wine ☐ mixed drinks • How much? _____

Do you use street drugs?: ☐ Yes ☐ No ☐ Quit • If Yes, how much?: _____ • What kind?_____

Do you drink caffeine?: ☐ Yes ☐ No • If Yes, how much:_____

Do you exercise regularly?: ☐ Yes ☐ No • If Yes, how often: _____

Have you been sexually abused, threatened or hurt by anyone? ☐ Yes ☐ No

Test	Last Test Date	Results Normal	Results Abnormal	Place / Physician
Pap Smear		☐	☐	
Mammogram		☐	☐	
Cholesterol		☐	☐	
Colonoscopy		☐	☐	
Pelvic Ultrasound		☐	☐	

Have you ever had:

	Yes	No		Yes	No		Yes	No		Yes	No
Frequent UTIs	☐	☐	Genital Warts	☐	☐	DES Exposure	☐	☐	Anemia	☐	☐
Chlamydia	☐	☐	Syphilis	☐	☐	Uterine Malformation	☐	☐	Hay Fever	☐	☐
Gonorrhea	☐	☐	Trichomonas	☐	☐	Abnormal Pap	☐	☐	Glaucoma	☐	☐
Herpes	☐	☐	Blood Transfusion	☐	☐	Infertility	☐	☐	Rheumatic Fever	☐	☐

Circle any recent or current health problems.

Feeling Tired or Poorly
Appetite Abnormal
Significant Weight Loss
Significant Weight Gain
Fever
Chills
Hot Flashes
Night Sweats
Intolerance to Heat
Intolerance to Cold
Excessive Thirst
Excessive Sweating
Loss of Hair
Numbness
Dizziness
Fainting
Seizures/Convulsions

Tremors
Anxiety
Depression
Sleep Problems
Memory Problems
Headaches
Vision Problems
Earache
Loss of Hearing
Nasal congestion
Nosebleeds
Difficulty Swallowing
Sore Throat
Swollen Glands in Neck
Breast Pain
Breast Lump
Nipple Discharge

Cough
Shortness of Breath
Chest Pain or Discomfort
Rapid or Irregular Heart Beat
Abdominal Pain
Nausea
Vomiting
Diarrhea
Constipation
Bloating
Indigestion / Heartburn
Blood in Stool
Pain During Urination
Frequent Urination
Urinary Loss of Control
Blood in Urine
Skin Rash

Easy Bleeding
Easy Bruising
Menstrual Cramping
Muscle Aches
Muscle Weakness
Joint Pain
Back Pain
Vulvar Itching or Burning
Vulvar Pain
Vulvar Lump or Mass
Labial Swelling
Vaginal Discharge
Vaginal Itching or Burning
Vaginal Pain
Vaginal Odor
Pelvic Pain
Pelvic Pressure

Patient Name: _____ Birth Date: _____

SELF AND FAMILY HISTORY

MGM - Maternal Grandmother MGF - Maternal Grandfather PMG - Paternal Grandmother PGF - Paternal Grandfather

Check ALL that apply.	Self	Mom	Dad	Sis	Bro	MGM	MGF	PGM	PGF
Diabetes type I (Child Onset)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes type II (Adult Onset)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clots in legs	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clots in lungs	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Varicose veins	☐	☐	☐	☐	☐	☐	☐	☐	☐
Endometriosis	☐	☐	■	☐	■	☐	■	☐	■
Birth defects	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple gestation (twins or more)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problems with anesthesia (Malignant Hyperthermia)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIV / AIDS	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neurologic problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures / Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Digestive problems (Crohn's, IBS, etc)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian cancer	☐	☐	■	☐	■	☐	■	☐	■
Uterine cancer	☐	☐	■	☐	■	☐	■	☐	■
Cervical cancer	☐	☐	■	☐	■	☐	■	☐	■
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Patient Adopted - No FHx

Other Patient History: _____

Other Family History: _____

Patient Name:_____ Birth Date:_____

IF YOU ARE PREGNANT
PLEASE COMPLETE THE REMAINDER OF THIS FORM

GENETICS SCREENING
Includes patient, baby's father, or anyone in either family with:

	YES	NO
1. Patient's age 35 years or older		
2. Thalassemia (Italian, Greek, Mediterranean, or Asian Background		
3. Neural tube defect (Meningomyelocele, Spina Bifida, or Anencephaly)		
4. Down Syndrome		
5. Tay-Sachs (eg. Jewish, Cajun, Fr. Canadian)		
6. Sickle Cell Disease or Trait (African)		
7. Hemophilia		
8. Muscular Dystrophy		
9. Cystic Fibrosis		
10. Huntington's Chorea		
11. Mental Retardation		
If yes, was person tested for Fragile X?		
12. Other inherited genetic or chromosomal disorder		
13. Patient or baby's father had a child with birth defects not listed above		
14. Spontaneous miscarriage or a stillbirth		
15. Have you used Medications/Street drugs/Alcohol since last menstrual period		
If yes, list agent(s):_____		
16. Any other genetic problems:_____		

INFECTION HISTORY: Patient Only

	YES	NO
1. Do you have any reason to believe you are high risk for HIV?		
2. Do you have any reason to believe you are high risk for Hepatitis B?		
3. Have you been immunized against Hepatitis B?		
4. Do you live with someone with TB or exposed to TB?		
5. Do you or your partner have a history of genital herpes?		
6. Have you had a rash or viral illness since your last menstrual period?		
7. Do you have a history of sexually transmitted diseases (Gonorrhea, Chlamydia, Warts, Syphilis)?		
8. Do you have any history of Pelvic Inflammatory Disease (PID) or infections of your tubes or ovaries?		

Have you had any problems with this pregnancy (bleeding, cramping, headaches, visual problems, backache, vaginal drainage?)

_____

_____

_____