

HEALTH HISTORY

Welcome to Siouxland Obstetrics and Gynecology. As a patient, please fill out the information found below to the best of your ability.

NAME: _____ **Birthdate:** _____ **Date:** _____

Are you here for a routine exam? _____

Are you having any problems? _____

GYN History: 1st day of your last period - _____

Problems with periods? - _____

PREGNANCIES # of pregnancies: _____

of deliveries: _____

of miscarriages: _____

of terminations: _____

Birth control method: (please circle) none, condoms, spermicidal, foam, DepoProvera, IUD (Mirena), IUD (Paraguard), birth control pills, birth control patch, birth control ring, tubal ligation, vasectomy

If **NOT** done in our office please list:

Date of last pap smear: _____

Normal: Y/N If no, results - _____

Any history of STD's: Y/N

(If yes, please list)

Date of last mammogram: _____

Normal: Y/N If no, results - _____

Date of bone density: _____

Normal: Y/N If no, results - _____

Have you received the HPV vaccination? Y/N

CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICATIONS:

(including herbal and non-prescriptions medications)

DO YOU REQUIRE ANTIBIOTICS PRIOR TO PROCEDURES? Y / N

PAST MEDICAL HISTORY (Have you ever had the following?)

Measles.....Y / N	Anemia.....Y / N	Back trouble.....Y / N
Mumps.....Y / N	Bladder infection.....Y / N	High blood pressure.....Y / N
Chickenpox.....Y / N	Epilepsy.....Y / N	Low blood pressure.....Y / N
Whooping cough.....Y / N	Migraines. Headaches.....Y / N	Hemorrhoids.....Y / N
Scarlet fever.....Y / N	Tuberculosis.....Y / N	Date of last chest x-ray.....
Diphtheria.....Y / N	Diabetes.....Y / N	Asthma.....Y / N
Small pox.....Y / N	Cancer.....Y / N	Hives or eczema.....Y / N
Rheumatic fever.....Y / N	Glaucoma.....Y / N	Infectious mono.....Y / N
Heart disease.....Y / N	Hernia.....Y / N	Bronchitis.....Y / N
Arthritis.....Y / N	Blood or plasma transfusion.....Y / N	Mitral valve prolapse.....Y / N
Hepatitis.....Y / N	Ulcer.....Y / N	Stroke.....Y / N
Thyroid disease.....Y / N	Kidney disease.....Y / N	Bleeding tendency.....Y / N

PLEASE EXPLAIN ANY IF NEEDED: _____

Are your vaccinations current? Y / N

PAST SURGERIES: _____

SOCIAL HISTORY: Occupation: _____ (exposures? _____)

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Alcohol use: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Tobacco use: Never: _____ Previous? _____ (quit: _____) Current packs per day: _____

Drug use: Never: _____ Previous? _____ (quit: _____) Drug: _____

FAMILY HISTORY: AGE DISEASE if deceased, age and cause of death (please list mother's or father's side of family)

Grandparents: _____

Father _____

Mother _____

Aunts/Uncles _____

Siblings _____

Children _____

GYN Review of Systems:	Irregular periodsY / N	Frequent urinationY / N
	Painful periods.....Y / N	Burning or painful urinationY / N
	Heavy or prolonged periods.....Y / N	Change in stream.....Y / N
	Absent periods.....Y / N	Difficulties emptying completely.....Y / N
	Pelvic Pain.....Y / N	Incontinence with activityY / N
	Abnormal vaginal bleedingY / N	Incontinence with urgencyY / N
	Abnormal sores or lesions.....Y / N	Kidney stonesY / N
	Painful intercourse.....Y / N	Facial hairY / N
	Vaginal itching or burning.....Y / N	Nipple discharge.....Y / N
	Vulvar itching or burningY / N	Breast lumpY / N
	Decreased sex drive.....Y / N	Breast pain.....Y / N
	Hot flashes or menopause symptoms.....Y / N	Vaginal drynessY / N

GENERAL REVIEW OF SYSTEMS:

Constitutional:	Good general health latelyY / N	Recent weight gainY / N	Recent weight lossY / N
	Fevers.....Y / N	Fatigue.....Y / N	HeadachesY / N
Eyes:	Eye disease or injuryY / N	Wear glasses/contactsY / N	Blurred or double vision.....Y / N
Ears/Nose/Mouth/Throat:	Hearing loss or ringing.....Y / N	Earaches or drainage.....Y / N	Mouth soresY / N
	Chronic sinus problems/rhinitisY / N	Nose bleeds.....Y / N	Swollen glands in neck.....Y / N
	Bleeding gums.....Y / N	Bad breath or bad tasteY / N	
Cardiovascular:	Heart troubleY / N	If yes explain: _____	
	Chest pain or angina.....Y / N	Palpitations.....Y / N	Shortness of breathY / N
	Swelling of the feet or ankles.....Y / N		
Respiratory:	Persistent coughY / N	PneumoniaY / N	Chronic bronchitisY / N
	Spitting up blood?Y / N	WheezingY / N	
Gastrointestinal:	Loss of appetiteY / N	change in bowel movementsY / N	Irritable bowel.....Y / N
	Nausea / vomiting.....Y / N	Frequent diarrhea.....Y / N	ConstipationY / N
	Painful bowel movementsY / N	Rectal bleedingY / N	Abdominal painY / N
Musculoskeletal:	Joint painY / N	Joint stiffnessY / N	Joint swelling.....Y / N
	Weakness in muscles.....Y / N	Muscle cramps.....Y / N	Back painY / N
	Cold extremities.....Y / N	Difficulty walking.....Y / N	
Skin:	Rash or itchingY / N	Change in skin color.....Y / N	Change in hair or nailsY / N
	Varicose veins.....Y / N		
Neurological:	HeadachesY / N	Light headed or dizzyY / N	Convulsions or seizuresY / N
	Numbness or tinglingY / N	TremorsY / N	ParalysisY / N
	Head injuryY / N		
Psychiatric:	Memory loss/ confusion.....Y / N	Nervous/ anxious.....Y / N	DepressionY / N
	Sleep disturbance.....Y / N		
Endocrine:	Excessive thirst/ urinationY / N	Heat/ cold intolerance.....Y / N	Dry skinY / N
Hematologic:	Slow to heal after cutsY / N	Bleeding bruising tendencyY / N	Anemia.....Y / N
	PhlebitisY / N	Past transfusionsY / N	Enlarged glandsY / N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services needed.

Patient signature: _____ Date: _____