

# Interval History

Welcome to Siouxland Obstetrics & Gynecology, PC. Please fill out the information found below and on the back to the best of your ability.

**Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Date of visit:** \_\_\_\_\_  
Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed  
Age: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work Phone#: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Is it ok to leave a detailed message? Home(Y/N): \_\_\_\_\_ Cell(Y/N): \_\_\_\_\_ Work(Y/N): \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Other Physician: \_\_\_\_\_

Are you here for a routine exam(Y/N): \_\_\_\_\_ Are you having problems(Y/N): \_\_\_\_\_

**GYN History:** 1<sup>st</sup> day of last period: \_\_\_\_\_ **Pregnancies:** # of pregnancies: \_\_\_\_\_  
Problems with periods(Y/N): if yes, please explain: \_\_\_\_\_ # 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:  
Date of last pap smear: \_\_\_\_\_ Any history of STD's: Y/N  
Normal: Y/N if no, results \_\_\_\_\_ 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  
Date of Diabetes Screen: \_\_\_\_\_  
Date of Cholesterol Screen: \_\_\_\_\_

**Current Medications:** \_\_\_\_\_ **Allergies to Medications:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(include herbal and non-prescriptions medications)

**Do you require Antibiotics prior to procedures: Y/N**

List any new surgeries since last seen: \_\_\_\_\_

List any new health conditions: \_\_\_\_\_

Do you use: Tobacco(Y/N) \_\_\_\_\_ If yes, how much: \_\_\_\_\_  
Alcohol(Y/N) \_\_\_\_\_ If yes, how much: \_\_\_\_\_  
Drugs(Y/N) \_\_\_\_\_ If yes, how much: \_\_\_\_\_

Any new family history: \_\_\_\_\_  
Are you current on tetanus shot and vaccinations(Y/N): \_\_\_\_\_  
List new vaccines since last seen: \_\_\_\_\_

# Review of Systems

Please check if you are currently experiencing any of these symptoms:

<b>Constitutional:</b>		<b>Gynecological:</b>	
	Fever		Bleeding or pain with intercourse
	Chills		Unusual vaginal discharge or odor
	Sweats		Vulvar or vaginal itching or burning
	Weight change-Gain or Loss		Pelvic Pain
	Weakness		
	Fatigue	<b>Urinary:</b>	
<b>Eyes:</b>			Painful urination
	Change in vision		Frequent Urination
			Urinary Urgency
			Blood in Urine
<b>Ears, Nose, Mouth, Throat:</b>			Urinary incontinence
	Change in hearing		Getting up at night to urinate
	Nose Bleeds		
	Sore Throat	<b>Musculoskeletal:</b>	
	Dry Mouth		Back Pain
			Weakness
<b>Cardiovascular:</b>			Joint Pain, stiffness, swelling
	Dizziness		
	Shortness of breath	<b>Intergumentary/Breast:</b>	
	Chest Pain		Nodules
	Loss of Consciousness		Change in moles, freckles
	Palpitations		Change in hair – growth, loss, texture
			Breast lumps
<b>Respiratory:</b>			Breast nipple discharge
	Chest Pain		Breast Pain
	Cough-productive or dry		
	Shortness of breath	<b>Neurological:</b>	
	Wheezing		Memory change
			Depression
<b>Gastrointestinal:</b>			Anxiety
	Abdominal pain		Mood Swings
	Nausea, vomiting		Numbness or tingling
	Change in bowel habits		
	Change in appetite	<b>Endocrine:</b>	
	Dark or Bloody Stools		Weight change
	Indigestion		Excessive thirst, urination
	Constipation or diarrhea		Tremor
			Cold or heat intolerance
<b>Hematologic/Lymphatic:</b>			
	Swollen lymph glands		
	Easy bruisability		

**Thank you for taking the time to answer these questions. Most insurance companies require this information to be updated at every visit.**