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

INITIAL MEDICAL HISTORY

For appointment on _____; _____,_____ at _____ am / pm with:
(day) (date) (time)

☐ Eckhart ☐ Anderson ☐ LaBeau ☐ Witthoeft ☐ Page ☐ Janecek ☐ Leppellere ☐ Lehman ☐ Fautsch

---

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

Patient Name: _____