Lincoln OB-GYN, P.C.

Name: _____ Date: _____

Your appointment is scheduled with (please circle):

Yvonne K. Davenport, M.D. Douglas A. DeBoise, M.D. Carol Greenlee, C.N.M
Gregory W. Heidrick, M.D. Dennis L. Hodge, M.D. Jill Dolberg, C.N.M.
Mary Dickerson, C.N.M.

Reason for today's visit? _____

Review of Systems:
If you have noticed any of these recently, please circle

Fatigue / night sweats / weakness /fainting
Impaired vision / blurred vision
Headaches / light headedness
Breast lumps / pain / nipple discharge
Chest Pain/palpitations
Shortness of breath/wheezing/chronic cough
Nausea/vomiting/diarrhea/constipation/blood in stools
Dysuria/incontinence/vaginal discharge/irregular vaginal bleeding/vaginal itching/pelvic pain
Swelling in hands/swelling in ankles/swelling in feet
Weight loss/thyroid problems
Difficulty sleeping/additional symptoms except as noted in the HPI

Obstetrical History: Please include miscarriages and abortions

Year	Sex	Baby's Weight	Term or Premature	Vaginal or Cesarean	Miscarriage	Abortion	Place	Doctor	Complications
1.									
2.									
3.									
4.									
5.									
6.									

Previous Surgical/Trauma History: Please include any surgery or trauma such as broken bones, concussions or injuries that you have had in the past.

Year	Type of Surgery/Trauma	Place	Doctor	Complications
1.				
2.				
3.				
4.				
5.				
6.				

Past Medical History: In the past have you had any of the following please circle

Frequent or severe headaches
Dizziness
Stroke
High blood pressure
Thyroid/glandular problems
Asthma, bronchitis, pneumonia
Epilepsy
Diabetes
Cancer
Anemia
Chickenpox, measles, or mumps

Breast disease
Gallbladder disease
Phlebitis/varicose veins
Eating disorders or significant weight loss
Infection of female organs
Ovarian cysts
Kidney/bladder infection
German measles
Hepatitis, mono, recent jaundice, or liver disease
High cholesterol
Have you ever been raped or abused

Did any of them require hospitalization? YES or NO

Are your vaccinations current (rubella, tetanus, etc.)? YES or NO

Contraceptive History:

Current type used (male or female):_____

If birth control pills, what kind and dosage:_____

Gynecologic History:

Menstrual History: Age at onset:_____ Length of time between periods:_____

How many days do you flow?_____ Do you have cramping?_._____

When was your last period? _____

History of any venereal disease such as warts, gonorrhea, Chlamydia, herpes:_____

Date of last Pap smear _____ History of abnormal Pap/when?_____

Have you had a mammogram? _____ Date of last mammogram_____

Did your mother take hormones/DES while carrying you? _____

Family History: Circle and indicate which family member.

High blood pressure
Stroke
Heart disease
Multiple Births
Birth defects (including mental retardation or Down's Syndrome)
Bleeding Disorders
Breast Disease

Kidney disease
Bleeding disorders
Anemia
Epilepsy
Thyroid Problems
Diabetes
Anemia
Cancer

Medication History:

List any Drug Allergies: _____

Current Medications and dosages: _____

_____

Social History: Do you use the following? If so, how much:

Cigarettes_____ Drugs _____

Alcohol _____