

Lincoln OB-GYN, P.C.

Name: _____

Date: _____

Your appointment is scheduled with (please circle):

Dennis L. Hodge, M.D.

Gregory W. Heidrick, M.D.

Yvonne K. Davenport, M.D.

Chandra K. Ljunggren, M.D.

Jessica M. Sandmeier, D.O.

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 | Breast disease |
| Dizziness | Gallbladder disease |
| Stroke | Phlebitis/varicose veins |
| High blood pressure | Eating disorders or significant weight loss |
| Thyroid/glandular problems | Infection of female organs |
| Asthma, bronchitis, pneumonia | Ovarian cysts |
| Epilepsy | Kidney/bladder infection |
| Diabetes | German measles |
| Cancer | Hepatitis, mono, recent jaundice, or liver disease |
| Anemia | High cholesterol |
| Chickenpox, measles, or mumps | 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 | Kidney disease |
| Stroke | Bleeding disorders |
| Heart disease | Anemia |
| Multiple Births | Epilepsy |
| Birth defects (including mental retardation or Down's Syndrome) | Thyroid Problems |
| Bleeding Disorders | Diabetes |
| Breast Disease | 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 _____