PEORIA WOMEN'S HEALTH
OBSTETRICS & GYNECOLOGY

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Date: _____

Name: _____ _____
First MI Last Maiden

Reason for Visit: _____ Date of Birth: _____ Age: _____

Primary Care Provider: _____

Personal Medical History (PLEASE CHECK ALL THAT APPLY):

- ❑ Diabetes, Type 1
- ❑ Diabetes, Type 2
- ❑ Gestational Diabetes
- ❑ Heart Disease
- ❑ Stroke
- ❑ Prior Blood Clot in legs or lungs
- ❑ Sickle Cell Disease/Trait
- ❑ Arthritis
- ❑ Blood Transfusion
- ❑ Seizures
- ❑ HIV/AIDS
- ❑ Frequent UTIs
- ❑ Kidney Disease
- ❑ Urinary Incontinence
- ❑ Asthma
- ❑ Lung Disease
- ❑ Skin Disease
- ❑ Chronic Yeast
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Breast Disease
- ❑ Thyroid Disease
- ❑ Intestinal Disease
- ❑ Bowel Disorder
- ❑ Stomach Problem
- ❑ HPV
- ❑ Migraine/Headaches
- ❑ Hepatitis
- ❑ Depression
- ❑ Anxiety
- ❑ Complications with Anesthesia
- ❑ STD: Please specify
- ❑ Herpes
- ❑ Mitral Valve Prolapse
- ❑ Cancer

Additional Illnesses: _____

Surgical History (PLEASE PROVIDE MONTH/YEAR FOR ALL THAT APPLY):

_____ /_____ Appendectomy
_____ /_____ Tonsilectomy
_____ /_____ Gallbladder
_____ /_____ Bladder
_____ /_____ Wisdom Teeth
_____ /_____ Orthopedic Surgery
_____ /_____ Brain Surgery
_____ /_____ Bowel
_____ /_____ Colonoscopy
_____ /_____ Lithotripsy
_____ /_____ Lung

Additional Surgeries: _____

Previous Gyne Surgical History (PLEASE PROVIDE MONTH/YEAR FOR ALL THAT APPLY):

_____ /_____ Colposcopy
_____ /_____ Cryotherapy
_____ /_____ Hysterectomy
_____ /_____ Cone Biopsy
_____ /_____ Removal of one or both ovaries
_____ /_____ Bilateral Tubal Ligation
_____ /_____ Breast Augmentation
_____ /_____ Cesarean Section
_____ /_____ Breast Biopsy (Left/Right)
_____ /_____ Ablation
_____ /_____ LEEP
_____ /_____ D&C
_____ /_____ Essure

Additional Surgeries: _____

Gynecology History (PLEASE COMPLETE ALL QUESTIONS THAT APPLY):

How old were you when you had your first menstrual period? _____ Menopause? _____

If you are currently having periods, what was the date of the first day of your last period? _____

Do your periods occur regularly? _____ How long do they typically last? _____

How do you consider your menstrual flow? Heavy Moderate Light Cycle Length

How do you consider your menstrual pain? Severe Moderate Light

Are you currently sexually active? _____

If yes, are you sexually active with Men, Women, or Both? _____

If so, how many partners have you had in the past 12 months? _____

Do you experience any pain or bleeding with intercourse? _____

What is your current method(s) of contraception?_____

Past method(s) of contraception? Any problems? _____

Obstetric History (PLEASE COMPLETE ALL QUESTIONS THAT APPLY):

Total Pregnancies:_____ Full Term Deliveries:_____ Preterm Deliveries:_____ Elective Abortions:_____

Miscarriages:_____ Ectopic Pregnancy:_____ Multiple Births:_____ Living Children:_____

Delivery Date	Weeks Pregnant	Length of Labor	Birth Wt.	Sex	Type of Delivery	Name of Child	Complications

Family Medical History (PLEASE LIST MOTHER / FATHER / SISTER / BROTHER / MATERNAL OR FRATERNAL GRANDPARENTS):

_____	Ovarian Cancer	_____	Heart Disease	_____	Diabetes
_____	Uterine Cancer	_____	Stroke	_____	Osteoporosis/Fracture
_____	Breast Cancer	_____	Hypertension	_____	Blood Clotting Disorders
_____	Colon Cancer				

Additional Diseases or Cancer Types: _____

Social History:

Do you smoke?	Yes	No	# of cigarettes per day:	
Do you drink alcohol?	Yes	No	# of drinks:	Frequency:
Do you use recreational drugs?	Yes	No	Type:	Frequency:
Are you employed?	Yes	No	If yes, where?	
What is your marital status:				
Who do you live with:				
Do you exercise regularly?	Yes	No	Type of exercise:	Frequency:
Do you consume caffeine regularly?	Yes	No	# of drinks per day;	Coffee/Tea/Soda/Other:
Do you wear seat belts regularly?	Yes	No		

Routine Health Screening History (PLEASE PROVIDE MONTH/YEAR FOR ALL THAT APPLY):

_____ /_____ Lipids Testing	Normal	Abnormal	_____
_____ /_____ Thyroid Testing	Normal	Abnormal	_____
_____ /_____ Other Blood Work	Normal	Abnormal	_____
_____ /_____ Most Recent Pap Smear	Normal	Abnormal	LSIL HSIL ASCUS ASCUS-H AGUS Unknown
_____ /_____ Previous Abnormal Pap Smear		Abnormal	LSIL HSIL ASCUS ASCUS-H AGUS Unknown
_____ /_____ Gonorrhea / Chlamydia	Negative	Positive	_____
_____ /_____ RPR (Syphilis) Testing	Negative	Positive	_____
_____ /_____ HSV (Herpes) Culture	Negative	Positive	_____
_____ /_____ HSV (Herpes) Blood Testing	Negative	Positive	_____
_____ /_____ HIV Testing	Negative	Positive	_____
_____ /_____ Mammogram	Normal	Abnormal	_____
_____ /_____ Bone Density	Normal	Abnormal	_____
_____ /_____ Colonoscopy	Normal	Abnormal	_____

Additional Health Screening: _____

Immunization History (PLEASE PROVIDE ALL THAT APPLY):

_____ /_____ Flu Vaccine _____ /_____ HPV Vaccine

_____ /_____ Pneumonia Vaccine _____ /_____ Zoster Vaccine

Additional Immunizations: _____

Please list <u>all</u> medications and dosages that you are currently taking (prescription, supplements, and over-the-counter):

_____

_____

Please list <u>all</u> medical allergies and symptoms (medicine, latex, etc.):

_____

_____

Please list <u>all</u> other allergies and symptoms (environmental, food, etc.):

_____