Peters & Kroeker
OBSTETRICS • GYNECOLOGY

Name _____ DOB: _____ Age: _____ Date: _____

Primary Care physician: _____ Reason for visit: _____

Are you pregnant now? _____ First day of last menstrual period: _____

Do you have any allergies? Y N if so, please list below:

To Medications? _____

To Foods? _____

To **Latex**? Y N

To **Iodine**? Y N

Reactions: _____

Are you taking any medications? If so, list them below:

Over the counter	Dose	Times per day	Reason for taking

Prescription	Dose	Times per day	Reason for taking

Are there any changes in your medical history?

_____

_____

_____

_____

Have you had any surgeries within the last year? Y N

If yes, please list:

_____

_____

_____

GYN History:

Age of first period: _____

Menstrual cycle:

Are you still having periods? Circle one: Yes / No

If yes, when was the first day of your last cycle? _____

Are your cycles regular or irregular? _____

What is the length of a typical cycle? _____

Is your flow heavy, medium or light? _____

How often do you change your pad or tampon on your heaviest day?

_____

Do you have painful sex? _____

Are you on birth control? Which? _____

Pap Smear History

When was your last pap smear? _____

Do you have a history of abnormal pap smear? _____

Have you had a colposcopy for an abnormal pap in the past? Circle one: Yes / No

Have you had any procedures for abnormal pap smears in the past?

Cryotherapy_____ LEEP_____ Cone biopsy _____

Mammography History

When was your last mammogram? _____

Do you have a history of an abnormal mammogram? _____

Have you had biopsies for abnormal mammogram? _____

History of sexually transmitted infections

Do you have a history of any of the following? (Circle if yes)

Herpes Syphilis Gonorrhea Chlamydia HIV

We want to get a better understanding of your sexual experiences and how they may impact you and your health. Have you had any unwanted sexual experiences? When?

_____

_____

_____

_____

Obstetrical History

Please list your pregnancies and their outcome in chronological order

Pregnancy	Year	Miscarriage, ectopic, or abortion?	How many weeks at delivery?	Type of delivery: Vaginal or cesarean section	Weight of baby at delivery	Sex of baby	Complications at the time of delivery?
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Healthcare Maintenance:

Most recent bone density scan (if done): _____
Most recent colonoscopy (if done): _____

Review of Systems:

	Yes	No		Yes	No		Yes	No
Abdominal Pain			Frequency			Pelvic Pain		
Back Pain			Hearing Loss			Shortness of Breath		
Blurred Vision			Heartburn			Sleep Disturbance		
Chest Pain			Hot Flashes			Vaginal Bleeding		
Confusion			Incontinence			Vaginal Discharge		
Constipation			Insomnia			Vaginal Dryness		
Diarrhea			Memory Loss			Vomiting		
Difficulty Urinating			Nausea			Weakness		
Dizziness			Nervous/anxious			Weight Gain		
Fatigue			Pain with Intercourse			Weight Loss		