Heartland Family First Medical Clinic
Guiding Hands Midwifery

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Office 402-884-6400
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Name _____ Age_____ DOB ____/____/____ Date ____/____/____
Best Phone # to reach you: _____

Pharmacy _____ **Location** _____ **Phone #** _____

Your answers on this form will help us better understand your medical concerns and conditions. If you are uncomfortable with any question, leave it blank. This may give you an opportunity to ask your family about specific health history conditions. Thank you!

Main reason for today's visit: _____

At what age did you begin having periods? _____
What was the first day of your last menstrual period? **LMP** ____/____/____
How many days do you typically bleed? _____ Is this painful? _____
How many days apart are your periods? From the first day of one bleed to the first day of the next bleed? _____
Are there any recent changes to your menstrual cycle that concern you? _____
If you are menopausal, at what age did your periods stop? _____

When was your last pap smear? _____ Result: _____
Have you had HPV screening? _____ If so, was it _____ negative? or _____positive?
Have you had treatment on your cervix due to an abnormal pap smear? ____ Describe_____
Last Mammogram? _____ Colonoscopy? _____ Hemacult? _____ Dexa scan? _____

Sexual History:

Have you ever had vaginal intercourse? ___yes ___no Are you currently sexually active? ___yes ____no
Do you have sexual concerns today? _____
At what age did you become sexually active? _____ Any history of sexual abuse or trauma? _____
Sexually attracted to _____men, _____women, _____ both
Have you had a new partner in the last 2 years?____no____yes
What do you currently do to prevent pregnancy? _____

Past birth control used: ____condoms ____birth control pills ____Nuva ring ____patch ____IUD ____vasectomy____withdrawal ____natural family planning ____vaginal film or other spermicide ____tubal ligation ____Essure ___Nexplanon____diaphragm

Have you ever been told you have: ____genital herpes ____chlamydia ____gonorrhea ____syphilis ____HIV
____pelvic inflammatory disease ____genital warts ____bacterial vaginosis ____yeast infection ____oral cold sores

Do you want to be screened for sexually transmitted infections today? ____yes ____no
(We routinely screen all women who are pregnant and all women less than 26 years of age per ACOG guidelines. Be sure to tell us if you do not want to be screened.)

Review of Systems: (Please indicate any *current* symptoms you may have)

____Fevers/chills/excessive sweating, ____Unexplained weight loss/gain/ fatigue
____Anxiety, ____Depression, ____Thoughts of suicide, ____Insomnia, ____Anger
____Headaches, ____migraines, ____Aura ,(sparks or spots with your migraine) ____Fainting, ____Memory loss
____Visual changes, ____Hearing loss, ____Bloody noses
____Cough, ____wheeze, ____Shortness of breath
____Heart palpitations, ____Chest pain
____Breast mass or lump, ____Nipple discharge, ____Breastfeeding, ____Painful breasts
____Abdominal or pelvic pain, ____Nausea/ vomiting/ diarrhea, ____Constipation, ____Blood in your stools
____Muscle/joint pain, ____Edema, ____Recent back pain or injury,
____Skin rash, ____New or change in a mole, ____Acne, ____ Easy bruising/bleeding gums
____Concern with sexual function, ___Vaginal discharge, ___Painful intercourse, ____Contraception need
____Leaking urine, ____Painful or bloody urination, ____Urinary frequency, ____Frequent urinary infections

Pregnancy History

_____ I have never been pregnant
_____ I have adopted children. Their names and ages are: _____

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopic and abortions

Year	M/F	Weeks Pregnant	Type of Delivery vaginal, C/S, forceps	Infant Weight	Length of labor	Childs name	Comments

Have you or the baby's father or anyone in either of your families, ever had any of the following:
(check any that apply)

_____Down Syndrome? If yes, who? _____
_____Neural tube defect (spina bifida, anencephaly)? If yes, who? _____
_____Hemophilia or other clotting abnormalities? Please explain _____
_____Muscular Dystrophy? If yes, who? _____
_____Cystic Fibrosis? If yes, who? _____Have you had screening? _____
_____Congenital Heart Defect? _____
_____Has anyone had more than 3 pregnancy losses?
_____Mental Retardation, Fragile X or Autism?
_____Huntington Chorea?
_____African ancestry or *Sickle Cell Trait*? Have you or baby's father been screened? _____
_____Jewish ancestry or *Tay-Sachs disease*? Have either of you been screened? _____
_____Italian, Greek, or Mediterranean background? Have either of you been tested for *B-Thalessemia*? _____
_____Philippine or Southeast Asian ancestry? Have either of you been tested for A-Thalessemia? _____
_____Canavan Disease? Familial Dysautonomia? (Ashkenazi Jewish ancestry). Have you been tested?_____
_____Other birth defects or concerns? _____
_____Other Chromosomal abnormality? If yes, please specify _____

Family History:

Please indicate your own family members (parents, siblings, child, grandparents (paternal or maternal), aunts/uncles (paternal or maternal) with any of the following conditions:

Cancer_____
What type?_____

Who?
Age?

Heart Disease_____
High blood pressure_____
Stroke_____
High Cholesterol_____
Blood clots/clotting disorder_____

Asthma_____
Kidney disease_____
Diabetes_____
Thyroid disease_____
Malignant hyperthermia____

Osteoporosis_____
Osteopenia _____
Marfan Syndrome_____
Other_____

Personal Medical History

Please indicate whether you personally have had any of the following medical problems (with date)

__Diabetes
__Cancer
__High blood pressure
__Stroke
__Asthma
__Heart disease
__Blood clots
__Heart attack
__Attempted suicide

__Depression
__Eating disorder
__Migraines
__Glaucoma
__Tuberculosis
__Hepatitis
__Epilepsy/seizures
__Thyroid problems
__Breast problems

__Polycystic ovarian syndrome
__Chronic back pain
__Blood in stools
__Rectal bleeding
__Constipation
__Leaking urine
__Gallbladder problems
__Blood disorder
_____

Medication Allergies:	Current Medications: (Please include hormones, vitamins, herbs, nonprescription medications and dosage)	Surgeries/ Hospitalizations: (please include the year)

Do you currently?:

Smoke? _____no _____yes _____packs, cigarettes/day.
Have a history of tobacco use? If so, what year did you quit?_____. (Good job!)
Drink alcohol? ____no ___yes
Have you ever felt you should *cut down* on your drinking? _____
Have people *annoyed* you by criticizing your drinking? _____
Have you ever felt bad or *guilty* about your drinking? _____
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?____
Currently celebrating ___years of sobriety!

Abuse prescription drugs or narcotics? _____no _____yes Have you used needles to inject drugs?_____
Have you used drugs other than those required for medical treatment? _____

Caffeine Use? ___servings/day _____rare _____none
Exercise? _____ Type: _____how often?_____

Eat or drink 3-4 servings of dairy or take a calcium supplement daily? ____yes _____no

Live in your own home with your own family? _____
Or do you share a residence with other families? _____
Do you have any minor children who do not live with you? _____

Marital Status:_____
Spouse or partners name: _____
In your relationship, is there any threatening, controlling or abusive behavior? _____

Are you employed outside the home? fulltime: ___ Part time:___ What is it you do?:_____

Work hazards/concerns _____