ROBERT D. PLAMBECK, M.D., P.C./OBSTETRICS & GYNECOLOGY

1001 South 70th Street, Suite 220 * Lincoln, NE 68510

Patient Name:_______________________________

Patient Date of Birth:_________________________

Have you ever been seen in this office: Y N

Patient Signature:_______________________________

What physician did/do you see?___________________

ALLERGIES

Do you have any DRUG allergies? Y N

Please list drug & reaction.

DRUG	REACTION

Food Allergy Y N ________________

Seasonal/Environmental Y N ________________

Other:____

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GYNECOLOGICAL HEALTH

Have you ever had any of the following? Please note date and treatment if applicable.

		DATE/TREATMENT
Recurrent Vaginal Infect	Y N	________________
Recurrent Bladder Infect.	Y N	________________
HIV+/AIDS	Y N	________________
Breast Lump or Cyst	Y N	________________
Pelvic Infections such as Gonorrhea or Chlamydia	Y N	________________
Endometriosis	Y N	________________
Uterine Fibroid	Y N	________________
Hep B/C	Y N	________________
Herpes	Y N	________________
HPV	Y N	________________
Pelvic Pain	Y N	________________
Irregular Bleeding	Y N	________________
Other	Y N	________________

IMMUNIZATIONS

		Date
Hepatitis B	Y N	________________
Human Papilloma Virus	Y N	________________
Tetanus/Diptheria	Y N	________________

PREVENTIVE SCREENING

		DATE
Mammogram	Y N	________________
Bone Density Study	Y N	________________
Colonoscopy-bowel study	Y N	________________
Lipid/Cholesterol Screen	Y N	________________

PAP SMEAR HISTORY

Date of Last Pap:_____________Normal Y N

Have you ever had an abnormal Pap Smear Y N

Date:_______________Results:________________

Action Taken		Date
Repeat Pap	Y N	________________
Colposcopy	Y N	________________
LEEP/Laser	Y N	________________
Cryotherapy	Y N	________________
Other	Y N	________________

FAMILY HISTORY

Do you or your blood relatives have any of the following: Please note Self, Maternal or Paternal.

	Relationship		Relationship
Blood Clotting Disorder Y N	________________________	Breast Cancer Y N	________________________
Cancer Y N	________________________	Cervical Cancer Y N	________________________
Cervical Pre-Cancer (Dysplasia) Y N	________________________	Colon Cancer Y N	________________________
Diabetes Y N	________________________	Heart Disease Y N	________________________
High Blood Pressure Y N	________________________	Osteoporosis Y N	________________________
Ovarian Cancer Y N	________________________	Stroke Y N	________________________
Uterine Cancer Y N	________________________	Melanoma Y N	________________________
Mental Illness Y N	________________________	Other	________________________

HEALTH HISTORY

Do you or have you experienced the following:

Y N	Anemia/Blood Disorder	Y N	Heart Problems	Y N	Osteoporosis
Y N	Artificial Valves	Y N	Hepatitis/Jaundice	Y N	Seizures
Y N	Blood Transfusion	Y N	High Blood Pressure	Y N	Stroke
Y N	Cancer	Y N	Kidney Problems	Y N	Thyroid Problems
Y N	Diabetes	Y N	Lupus	Y N	**
Y N	Respiratory Problems	Y N	Migraine Headaches	Y N	**
Y N	Epilepsy	Y N	Mitral Valve Prolapse	Y N	**
Y N	Fever Blisters				

OTHER:____

Other Physicians Providing Care:______________________________________

SOCIAL HISTORY

Do you use illegal drugs? If so, what?_____________

Do you use alcohol? If so, how much?_____________

Do you smoke? If so, how much & how long?

____

Primary Language spoken: ________________

Interpreter needed: Y N

TRAVEL

Have you recently traveled abroad? Y N

If yes, Where?_________________________

MEDICATIONS

List all medications you are currently taking including any over the counter medications. Please include dosage and the reason you take the medication.

Example:Lipitor, 20 mg 1 time daily, High Cholesterol

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CONTRACEPTIVE HISTORY

Current Use___________________________

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Past Use_____________________________

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SURGERIES/HOSPITALIZATIONS

Please list any surgeries/hospitalizations.Include Dates.

Example: Appendectomy, 8-2000

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PREGNANCY

Are you pregnant? _____ Unsure _____ No

_____ Yes _____ Estimated # of weeks

Have you ever been pregnant? Y N

If "yes", please list a number for the following:

_____ Pregnancies
_____ Live Birth Deliveries
_____ Miscarriages
_____ Induced Abortions
_____ Ectopic Pregnancies
_____ Stillbirths
_____ Pre-Term Deliveries (less than 37 weeks)
_____ Term Pregnancies (over 37 weeks)
_____ Vaginal Deliveries
_____ C-Section Deliveries
_____ Breech Deliveries
_____ VBAC Deliveries

Any complications of pregnancy? Y N

Please

Describe:___________________________

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PLEASE USE ADDITIONAL PAPER IF MORE EXPLANATION IS REQUIRED (Revised 01/10)