Women's Clinic of Lincoln, P.C.
Specialists in Obstetrics and Gynecology

Stephen G Swanson, MD, FACOG
James J Maly, MD, FACOG
Rachel M Swim, MD
Jenna N Van Pelt, MD
Svjetlana Dziko, MD

DATE	ACCOUNT #	APRN	SCANNED

Full Name	Preferred First Name	Date of Birth	Age

Primary Contact Phone #		Marital Status		Whom do you live with? (i.e. Spouse, parents)
May we leave personal messages at this #?	☐ Yes ☐ No	☐ Married ☐ Single ☐ Divorced	☐ Separated ☐ Widowed ☐ Engaged	

Ethnicity		Race		
	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown		☐ American Indian/Alaskan Native ☐ African American/Black ☐ Native Hawaiian or Pacific Islander	☐ Asian ☐ White/Caucasian ☐ Other:

Preferred OB Doctor	Preferred Hospital	Preferred Pharmacy & Location	Family Practice Doctor
☐ Dr. Stephen Swanson ☐ Dr. James Maly ☐ Dr. Svjetlana Dziko ☐ Dr. Rachel Swim ☐ Dr. Jenna Van Pelt	☐ Bryan East ☐ St. Elizabeth		
		Other Doctors in your care	Pediatrician (**Baby Doctor**)

Current Employment		Place of Employment/School	Occupation
☐ Working ☐ Homemaker	☐ Student ☐ Unemployed		
Work Contact Phone #		May we contact you &/or leave messages at this #?	☐ Yes ☐ No

Name of Father of Baby/Partner		Contact Phone #	Involved in the pregnancy?
			☐ Yes ☐ No
Current Employment		Place of Employment/School	Occupation
☐ Working ☐ Student	☐ Unemployed		

If you have **Children** List their name/age/sex			
Do all of your children live with you?	☐ Yes ☐ No	If **NO**: Please Explain WHY?	
Does the Father of the Baby have other Children with a different partner?	☐ Yes ☐ No	If **YES**: List name/age/sex:	
Do your children have the same biological father as the father of the baby in the current pregnancy?	☐ Yes ☐ No		

Other Support Person: List your Relationship & Contact phone #	
Whom may we contact if unable to reach you after several attempts? (*It needs to be someone we can inform to tell you that the Women's Clinic of Lincoln has been attempting to reach you*)	

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Medications & Vitamins **Please include Dosage & how often you take it** For prescription medication, please list who prescribes it for you	**Allergies** to Medications, Foods or Substances (Please include reaction to each & approx. year when it occurred)
List medications that you have **recently stopped taking** & *WHY* you stopped	List any **over-the-counter** Medications you have taken since the beginning of this pregnancy

CURRENT PREGNANCY HISTORY			
LMP Date:	Date of Positive Test:	Planned Pregnancy:	Emotional Status:
		☐ Yes ☐ No	☐ Good ☐ Poor
Pregnancy Attained:	If Pregnancy was Attained with Assistance (if applicable)		
☐ No Assistance ☐ With Assistance by: ☐ Women's Clinic ☐ Other →	☐ Oral Meds ☐ Injections ☐ IUI (Insemination) ☐ In Vitro	☐ Donor Egg ☐ Donor Sperm	Reproductive Endocrinologist Doctor
If you have had any blood work or an ultrasound since your LMP, explain WHY & where it was done below:		If you have been evaluated at the Women's Clinic for any reason since your LMP date: Explain WHY and NP/MD you worked with. (i.e. spotting, vaginitis, nausea/vomiting, etc)	
Any Complaints since LMP?		Other significant complaints, describe:	
☐ Nausea ☐ Vomiting ☐ Vaginal Irritation	☐ Pain with Urination ☐ Spotting (when?)		

PAST PREGNANCY HISTORY											
# of times Pregnant		# of Living Children									
Select below if you have had a:					Describe Here: Please include Year & Doctor/Location						
☐ Stillbirth ☐ Ectopic (Tubal) ☐ Molar Pregnancy ☐ Elective Termination (Abortion) →											
☐ Miscarriage ↓ (If > 3 losses, list on back)											
Date:		# of weeks:		D&C:	Y N	Chromosomes:	Y N	Results:			
Date:		# of weeks:		D&C:	Y N	Chromosomes:	Y N	Results:			
Date:		# of weeks:		D&C:	Y N	Chromosomes:	Y N	Results:			

DELIVERY INFORMATION
If you have delivered with our clinic in the past 5 years, you do not need to fill this portion out

Date	Weeks	Hours Labor	Birth Wt	Gender	Child Name	Vag/C-S	Epidural	Doctor	Hospital	Problem ***
				M F		Vag C-S	Y N			Y N
				M F		Vag C-S	Y N			Y N
				M F		Vag C-S	Y N			Y N
				M F		Vag C-S	Y N			Y N
				M F		Vag C-S	Y N			Y N
				M F		Vag C-S	Y N			Y N
				M F		Vag C-S	Y N			Y N
				M F		Vag C-S	Y N			Y N

***Describe what problems/complications you experienced:

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Please indicate if you experienced any of the following during Pregnancy:

- ☐ Cerclage for cervical incompetence
- ☐ FFN + (Fetal Fibronectin Positive)
- ☐ Received Steroids for Fetal Lung Maturity
- ☐ Received weekly P17 (Progesterone) injections to prevent Premature Labor
- ☐ Premature Delivery (prior to 37 weeks)
  - ☐ Known Reason ______________________
  - ☐ Unknown Reason
- ☐ Premature rupture of membranes (prior to 37 weeks)
  - ☐ Known Reason ______________________
  - ☐ Unknown Reason
- ☐ Hospitalized for Severe Vomiting
- ☐ Multiple Gestation: Twins, Triplets, Quads, etc.
- ☐ Vanishing Twin
- ☐ Growth Restricted Baby—Small or Poor Growth
- ☐ Large Baby-> 10lbs
- ☐ Polyhydramnios-too much amniotic fluid
- ☐ Oligohydramnios-too little amniotic fluid
- ☐ Placenta abnormalities
- ☐ Gestational Diabetes (Diet, oral meds, or insulin)
  - ☐ Diet controlled
  - ☐ Oral Medication—What Med______________
  - ☐ Insulin injections
- ☐ High blood pressure that developed during pregnancy:
  - ☐ On Medication—What med_______________
    - ☐ During Pregnancy
    - ☐ During Pregnancy & Postpartum
    - ☐ Postpartum ONLY
  - ☐ Protein in urine
  - ☐ Blood work abnormalities
  - ☐ **NO** blood work abnormalities or protein in urine
- ☐ Have had a Cesarean, WHY?
  - ☐ Fetal Distress
  - ☐ Position: Breech, Transverse
  - ☐ Failure to Progress
  - ☐ CPD: Pelvis too small
  - ☐ Repeat c/s-First one due to_____________
- ☐ VBAC: Vaginal Birth After Cesarean
- ☐ Postpartum Hemorrhage with Blood Transfusion

Explain any SIGNIFICANT information from above:

PERSONAL GYNECOLOGICAL HISTORY

Menstrual Cycle

Age at First Menstrual Cycle	Cycle Length (i.e. 28 days)	# Days Cycle Lasts (i.e. 5 days)	Amount of Cycle Flow	Cramping
			☐ Light ☐ Medium ☐ Heavy	☐ Mild ☐ Moderate ☐ Severe

Pap Smear History

Date of Last Pap Smear:		Have you ever had an Abnormal Pap Smear :	☐ Yes ☐ No

IF an Abnormal History Explain Here: →	Procedure/s Performed	Year	Procedure/s Performed	Year	Office Notes:
	☐ Re-pap only		☐ Cone Biopsy		
	☐ Colposcopy		☐ Cryotherapy		
	☐ LEEP				

Please list any SIGNIFICANT Result History (HPV, CIN, etc)	
What Doctor/Clinic have you had your pap smears done since you started having them?	☐ Women's Clinic of Lincoln ☐ Other:

GYNECOLOGICAL CONDITION HISTORY

CONDITION	Year & Age	Details & Doctor	CONDITION	Year & Age	Details & Doctor
☐ Chlamydia			☐ Endometriosis		
☐ Gonorrhea			☐ Uterine Fibroids		
☐ Trichomonasis			☐ Uterine Anomalies		
☐ Genital Herpes			☐ Infertility		
☐ HPV			☐ Ovarian Cysts		
☐ Condyloma (Warts)			☐ PCOS		
☐ Recurrent Vag Infection			☐ Breast Lump/Cyst		
☐ PID			☐ Other:		

SURGICAL HISTORY: Please list type of surgery and approximate year it was done AND ANY HOSPITALIZATIONS FOR ACCIDENTS/PROBLEMS (reason/year)

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PERSONAL HEALTH HISTORY

CONDITION	Year & Age	Details & Doctor
CARDIAC CONDITIONS		
☐ High BP; Non-pregnant		
☐ High BP; Pregnant		
☐ High Cholesterol		
☐ Heart Murmur (ADULT)		
☐ Other Heart Condition:		
GASTROINTESTINAL CONDITIONS		
☐ Irritable bowel (IBS)		
☐ Gallbladder Disease		
☐ Liver Disease		
☐ GERD/Heartburn		
☐ Celiac Disease		
☐ Crohn's		
☐ Ulcerative Colitis		
☐ Other GI Conditions:		
MUSCULOSKELATAL CONDITIONS		
☐ Back Disorders		
☐ Osteopenia-Bone Loss		
☐ Rheumatoid Arthritis		
☐ Other Muscle/Bone:		
PSYCHIATRIC CONDITIONS		
☐ Anxiety		
☐ Depression		
☐ Postpartum Depression		
☐ Bipolar		
☐ PTSD		
☐ ADHD/ADD		
☐ Anorexia		
☐ Bulimia		
☐ Other Conditions:		
NEUROLOGIC CONDITIONS		
☐ Migraine Headaches		
☐ Seizure Disorder		
☐ Multiple Sclerosis (MS)		
☐ Other Conditions:		
CANCER		
☐ Cancer		
GENETIC OR CONGENITAL DISORDERS		
☐ Explain:		

CONDITION	Year & Age	Details & Doctor
BLOOD & CLOTTING CONDITIONS		
☐ Anemia		
☐ Sickle Cell Anemia		
☐ Thalassemia		
☐ Thrombocytopenia		
☐ Factor V Leiden		
☐ Deep Vein Thrombosis		
☐ Pulmonary Embolism		
☐ Other Blood/Clotting:		
ENDOCRINE CONDITIONS		
☐ Diabetes: Type 1		
☐ Diabetes: Type 2		
☐ Obesity		
☐ Insulin Resistance		
☐ Hypothyroidism		
☐ Hyperthyroidism		
☐ Other Endocrine:		
RESPIRATORY CONDITIONS		
☐ Asthma		
☐ Asthma-Exercise		
☐ Allergies		
☐ Other Lung Conditions		
BLADDER & KIDNEY CONDITIONS		
☐ Chronic UTI's		
☐ Interstitial Cystitis (IC)		
☐ Kidney Stones		
☐ Other Condition:		
OTHER AUTOIMMUNE CONDITIONS		
☐ Lupus		
☐ ANA Positive		
☐ Anti-phospholipid		
☐ Other:		
INFECTIOUS CONDITIONS		
☐ Cold Sores		
☐ Shingles		
☐ Hepatitis B		
☐ Hepatitis C		
☐ Tuberculosis (TB)		
☐ HIV		
☐ Syphilis		
☐ MRSA Infection		
☐ Other:		

Other SIGNIFICANT Personal Health History:

PERSONAL HEALTH INFORMATION		Explain: Details/Information, Including Year/Age
Have you ever had a mammogram or breast ultrasound?	☐ Yes ☐ No	
Have you had Genetic Carrier Screening (Pre-Conception screening)?	☐ Yes ☐ No	
Have you had Genetic Testing for Hereditary Conditions (i.e. Cancer)	☐ Yes ☐ No	
Have you ever had a blood transfusion?	☐ Yes ☐ No	
Have you received the Gardasil Vaccine for HPV?	☐ Yes ☐ No	
Have you had the Chicken Pox (Varicella) or did you receive the Vaccine?	☐ Had Chicken Pox as a Child ☐ Had Chicken Pox as an Adult ☐ Unknown	☐ Received Vaccine ☐ Have NOT received Vaccine OR ever had Chicken Pox

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FAMILY HEALTH HISTORY

☐ ADOPTED—Family History UKNOWN ☐ ADOPTED---Family History KNOWN

List your Parents, siblings & other family members (blood related) & write in approximate age of onset

DISEASE/CONDITION	Family Mother's Side	Family Father's Side	Age of Diagnosis	Details/Information: Still Living or medicated
☐ Breast Cancer				
☐ Other Breast Condition				
☐ Ovarian Cancer				
☐ Other Cancers: Colon, Prostate, Lung, Skin				Type:
☐ Gynecological Conditions (i.e. Fibroids, etc)				
☐ Obstetrical Problems				
☐ High Blood Pressure				Medicated
☐ High Cholesterol				Medicated
☐ Heart Attack				
☐ Stroke/TIA				
☐ Clotting Disorders				
☐ DVT (Deep Vein Thrombosis)				
☐ PE (pulmonary embolus)				
☐ Thyroid Condition				
☐ Diabetes-Type 1 (Juvenile-insulin)				
☐ Diabetes-Type 2 (Adult Onset)				Medicated or diet controlled
☐ Gestational Diabetes				
☐ Anxiety or Depression, other Mental Condition				
☐ Neuro Disorder (i.e. MS, Alzheimer's, etc)				
☐ Lung Conditions				
☐ Stomach, Gallbladder, Liver, Bowel Conditions				
☐ Bone/Muscle/Joint Condition (i.e. Osteoporosis, etc)				
☐ Kidney or Bladder Condition				
☐ Autoimmune Condition (i.e. Lupus, etc)				
☐ Infectious (i.e. Tuberculosis, Hepatitis, etc)				

Any other **IMPORTANT or SIGNIFICANT** details about Family History Conditions:

If you have Children, Does a child have any SIGNIFICANT health history?	Explain:

GENETIC & CONGENTIAL (BIRTH DEFECT) SCREENING

- ✓ Genetic/Congenital Disorder History in **YOUR** family & the **FATHER** of the baby's family (blood related ONLY)
- ✓ Below is a partial list of Congenital Birth Defects, Genetic Disorders & Chromosomal Abnormalities
- ✓ PLEASE include any other conditions or disorders that are not listed

☐ You were ADOPTED; family history is unknown
☐ You were ADOPTED: family history KNOWN
☐ Father was ADOPTED & family history UNKNOWN
☐ Father was ADOPTED & family history KNOWN

☐ Anencephaly
☐ Arnold-Chiari Malformation
☐ Cleft Lip
☐ Cleft Palate
☐ Club Foot
☐ Congenital Heart Defects
☐ Diaphragmatic Hernia
☐ Ear or Eye abnormalities
☐ Gastroschisis
☐ Hirschsprung's Disease
☐ Hypospadias
☐ Limb abnormalities/reductions
☐ Omphalocele
☐ Spina Bifida
☐ Tracheoesophageal Fistula
☐ Other:

☐ Autism
☐ Canavan's Disease
☐ Charcot-Marie-Tooth Disease
☐ Cystic Fibrosis
☐ Duchenne Muscular Dystrophy
☐ Fragile X (Mental Retardation)
☐ Hemophilia
☐ Huntington's Chorea
☐ Marfan's Disease
☐ Neurofibromatosis
☐ Parkinson's Disease
☐ Phenylketonuria (PKU)
☐ Polycystic Kidney Disease
☐ Sickle Cell Disease or Trait (African American)
☐ Spinal Muscular Atrophy (SMA)
☐ Tay-Sachs
☐ Thalassemia

Chromosome Abnormalities
☐ Trisomy 21 (Down Syndrome)
☐ Trisomy 18 (Edwards Syndrome)
☐ Trisomy 13 (Patau Syndrome)
☐ Triploidy

Sex Chromosomes Abnormalities
☐ Turner's Syndrome (Monosomy X)
☐ Triple X
☐ XYY Syndrome
☐ Klinefelter Syndrome

Microdeletions
☐ 22q11.2 Deletion Syndrome (DiGeorge)
☐ 1p36 Deletion Syndrome
☐ Angelman Syndrome
☐ Prader-Willi Syndrome
☐ Cri-du-chat Syndrome

☐ **NONE known**	**EXPLAIN if a condition was selected from above and who was affected:**

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SUBSTANCE USE

Question	Status	Details			
Do you smoke Cigarettes?	☐ Currently	# Cigarettes/Day: Age started:	/DAY	Total Years =	
		Are you interested in smoking cessation?		☐ Yes ☐ No	
	☐ Former	Age started: Age QUIT:		Total Years =	
	☐ Socially ☐ Never				
Do you use other forms or tobacco or nicotine?	☐ E-Cigarettes ☐ Nicotine Gum ☐ Cigars	☐ Chew ☐ Pipe	Explain history of use:		
Do you have second-hand smoke exposure?	☐ Yes ☐ No	If Yes, Explain:			
Do you use recreational drugs?	☐ Currently ☐ Former ☐ Never	☐ Marijuana ☐ Methamphetamine ☐ Narcotic Abuse ☐ Other:	Have you ever been in rehab for drug addiction? If so Where? →	☐ Yes ☐ No	
Have you ever shared needles for IV drug use?	☐ Yes ☐ No	If Yes, Explain:			
Do you currently drink Caffeine?	☐ Yes ☐ No	☐ Coffee ☐ Soda Pop	☐ Tea ☐ Energy Drinks	# cups or cans/day	
Have you consumed alcohol while pregnant?	☐ Yes ☐ No	Explain:			

HEALTH HABITS & SOCIAL HISTORY

Question	Answer	Details
Do you eat undercooked meat or raw sushi?	☐ Yes ☐ No	If Yes, Explain:
Do you work with chemicals/radiation?	☐ Yes ☐ No	If Yes, Explain:
Do you change cat litter?	☐ Yes ☐ No	Who will do it while you are pregnant?
Do you exercise on regular basis?	☐ Yes ☐ No	Explain what you do and how often:
Do you go to the dentist regularly?	☐ Yes ☐ No	Last Exam Date:
Do you have any physical impairments or handicaps?	☐ Yes ☐ No	If Yes, Explain:
Have you experienced any physical, emotional, or sexual abuse?	☐ Yes ☐ No	If Yes, Explain:
Do you feel safe in your relationship?	☐ Yes ☐ No	If NO, Explain:
Do you have any major stressors in your life at this time?	☐ Yes ☐ No	If Yes, Explain:
Do you have any Religious Beliefs we need to be Aware of?	☐ Yes ☐ No	If Yes, Explain:
What is the highest level of education you have received?		What is the highest level of education the FATHER of the baby has received?

List below if you have any concerns about this pregnancy?

Signature: ____ *Date:* ________________________