



Women's Clinic of Lincoln, P.C.

Specialists in Obstetrics and Gynecology

Stephen G. Swanson, MD, FACOG

James J. Maly, MD, FACOG

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 #? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Engaged	
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown	Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> African American/Black <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other:	

Preferred OB Doctor	Preferred Hospital	Preferred Pharmacy & Location	Family Practice Doctor
<input type="checkbox"/> Dr. Stephen Swanson <input type="checkbox"/> Dr. James Maly <input type="checkbox"/> Dr. Svjetlana Dziko	<input type="checkbox"/> Bryan East		
		Other Doctors in your care	Pediatrician (Baby Doctor)

Current Employment	Place of Employment/School	Occupation
<input type="checkbox"/> Working <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Unemployed		
Work Contact Phone #	May we contact you &/or leave messages at this #?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Father of Baby/Partner	Contact Phone #	Involved in the pregnancy?
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Current Employment	Place of Employment/School	Occupation
<input type="checkbox"/> Working <input type="checkbox"/> Student <input type="checkbox"/> Unemployed		

If you have Children List their name/age/sex			
Do all of your children live with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If NO : Please Explain WHY?	
Does the Father of the Baby have other Children with a different partner?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> 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:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Good <input type="checkbox"/> Poor
Pregnancy Attained:	If Pregnancy was Attained with Assistance (if applicable)		
<input type="checkbox"/> No Assistance <input type="checkbox"/> With Assistance by: <input type="checkbox"/> Women's Clinic → <input type="checkbox"/> Other	<input type="checkbox"/> Oral Meds <input type="checkbox"/> Injections <input type="checkbox"/> IUI (Insemination) <input type="checkbox"/> In Vitro	<input type="checkbox"/> Donor Egg <input type="checkbox"/> 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:	
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vaginal Irritation	<input type="checkbox"/> Pain with Urination <input type="checkbox"/> Spotting (when?)		

PAST PREGNANCY HISTORY									
# of times Pregnant		# of Living Children		Describe Here: Please include Year & Doctor/Location					
Select below if you have had a:									
<input type="checkbox"/> Stillbirth									
<input type="checkbox"/> Ectopic (Tubal)									
<input type="checkbox"/> Molar Pregnancy									
<input type="checkbox"/> Elective Termination (Abortion)									
<input type="checkbox"/> 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:

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Cerclage for cervical incompetence <input type="checkbox"/> FFN + (Fetal Fibronectin Positive) <input type="checkbox"/> Received Steroids for Fetal Lung Maturity <input type="checkbox"/> Received weekly P17 (Progesterone) injections to prevent Premature Labor <input type="checkbox"/> Premature Delivery (prior to 37 weeks) <ul style="list-style-type: none"> <input type="checkbox"/> Known Reason _____ <input type="checkbox"/> Unknown Reason <input type="checkbox"/> Premature rupture of membranes (prior to 37 weeks) <ul style="list-style-type: none"> <input type="checkbox"/> Known Reason _____ <input type="checkbox"/> Unknown Reason <input type="checkbox"/> Hospitalized for Severe Vomiting <input type="checkbox"/> Multiple Gestation: Twins, Triplets, Quads, etc. <input type="checkbox"/> Vanishing Twin <input type="checkbox"/> Growth Restricted Baby—Small or Poor Growth <input type="checkbox"/> Large Baby-> 10lbs <input type="checkbox"/> Polyhydramnios-too much amniotic fluid <input type="checkbox"/> Oligohydramnios-too little amniotic fluid <input type="checkbox"/> Placenta abnormalities | <ul style="list-style-type: none"> <input type="checkbox"/> Gestational Diabetes (Diet, oral meds, or insulin) <ul style="list-style-type: none"> <input type="checkbox"/> Diet controlled <input type="checkbox"/> Oral Medication—What Med _____ <input type="checkbox"/> Insulin injections <input type="checkbox"/> High blood pressure that developed during pregnancy: <ul style="list-style-type: none"> <input type="checkbox"/> On Medication—What med _____ <ul style="list-style-type: none"> <input type="checkbox"/> During Pregnancy <input type="checkbox"/> During Pregnancy & Postpartum <input type="checkbox"/> Postpartum ONLY <input type="checkbox"/> Protein in urine <input type="checkbox"/> Blood work abnormalities <input type="checkbox"/> NO blood work abnormalities or protein in urine <input type="checkbox"/> Have had a Cesarean, WHY? <ul style="list-style-type: none"> <input type="checkbox"/> Fetal Distress <input type="checkbox"/> Position: Breech, Transverse <input type="checkbox"/> Failure to Progress <input type="checkbox"/> CPD: Pelvis too small <input type="checkbox"/> Repeat c/s-First one due to _____ <input type="checkbox"/> VBAC: Vaginal Birth After Cesarean <input type="checkbox"/> Postpartum Hemorrhage with Blood Transfusion |
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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
			<input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Pap Smear History

Date of Last Pap Smear:	Have you ever had an Abnormal Pap Smear :			<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF an Abnormal History Explain Here: →	Procedure/s Performed	Year	Procedure/s Performed	Year	Office Notes:
	<input type="checkbox"/> Re-pap only		<input type="checkbox"/> Cone Biopsy		
	<input type="checkbox"/> Colposcopy		<input type="checkbox"/> Cryotherapy		
Please list any SIGNIFICANT Result History (HPV, CIN, etc)					
What Doctor/Clinic have you had your pap smears done since you started having them?			<input type="checkbox"/> Women's Clinic of Lincoln <input type="checkbox"/> Other:		

GYNECOLOGICAL CONDITION HISTORY

CONDITION	Year & Age	Details & Doctor	CONDITION	Year & Age	Details & Doctor
<input type="checkbox"/> Chlamydia			<input type="checkbox"/> Endometriosis		
<input type="checkbox"/> Gonorrhea			<input type="checkbox"/> Uterine Fibroids		
<input type="checkbox"/> Trichomonosis			<input type="checkbox"/> Uterine Anomalies		
<input type="checkbox"/> Genital Herpes			<input type="checkbox"/> Infertility		
<input type="checkbox"/> HPV			<input type="checkbox"/> Ovarian Cysts		
<input type="checkbox"/> Condyloma (Warts)			<input type="checkbox"/> PCOS		
<input type="checkbox"/> Recurrent Vag Infection			<input type="checkbox"/> Breast Lump/Cyst		
<input type="checkbox"/> PID			<input type="checkbox"/> 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	CONDITION	Year & Age	Details & Doctor
CARDIAC CONDITIONS			BLOOD & CLOTTING CONDITIONS		
<input type="checkbox"/> High BP; Non-pregnant			<input type="checkbox"/> Anemia		
<input type="checkbox"/> High BP; Pregnant			<input type="checkbox"/> Sickle Cell Anemia		
<input type="checkbox"/> High Cholesterol			<input type="checkbox"/> Thalassemia		
<input type="checkbox"/> Heart Murmur (ADULT)			<input type="checkbox"/> Thrombocytopenia		
<input type="checkbox"/> Other Heart Condition:			<input type="checkbox"/> Factor V Leiden		
GASTROINTESTINAL CONDITIONS			<input type="checkbox"/> Deep Vein Thrombosis		
<input type="checkbox"/> Irritable bowel (IBS)			<input type="checkbox"/> Pulmonary Embolism		
<input type="checkbox"/> Gallbladder Disease			<input type="checkbox"/> Other Blood/Clotting:		
<input type="checkbox"/> Liver Disease			ENDOCRINE CONDITIONS		
<input type="checkbox"/> GERD/Heartburn			<input type="checkbox"/> Diabetes: Type 1		
<input type="checkbox"/> Celiac Disease			<input type="checkbox"/> Diabetes: Type 2		
<input type="checkbox"/> Crohn's			<input type="checkbox"/> Obesity		
<input type="checkbox"/> Ulcerative Colitis			<input type="checkbox"/> Insulin Resistance		
<input type="checkbox"/> Other GI Conditions:			<input type="checkbox"/> Hypothyroidism		
MUSCULOSKELATAL CONDITIONS			<input type="checkbox"/> Hyperthyroidism		
<input type="checkbox"/> Back Disorders			<input type="checkbox"/> Other Endocrine:		
<input type="checkbox"/> Osteopenia-Bone Loss			RESPIRATORY CONDITIONS		
<input type="checkbox"/> Rheumatoid Arthritis			<input type="checkbox"/> Asthma		
<input type="checkbox"/> Other Muscle/Bone:			<input type="checkbox"/> Asthma-Exercise		
PSYCHIATRIC CONDITIONS			<input type="checkbox"/> Allergies		
<input type="checkbox"/> Anxiety			<input type="checkbox"/> Other Lung Conditions		
<input type="checkbox"/> Depression			BLADDER & KIDNEY CONDITIONS		
<input type="checkbox"/> Postpartum Depression			<input type="checkbox"/> Chronic UTI's		
<input type="checkbox"/> Bipolar			<input type="checkbox"/> Interstitial Cystitis (IC)		
<input type="checkbox"/> PTSD			<input type="checkbox"/> Kidney Stones		
<input type="checkbox"/> ADHD/ADD			<input type="checkbox"/> Other Condition:		
<input type="checkbox"/> Anorexia			OTHER AUTOIMMUNE CONDITIONS		
<input type="checkbox"/> Bulimia			<input type="checkbox"/> Lupus		
<input type="checkbox"/> Other Conditions:			<input type="checkbox"/> ANA Positive		
NEUROLOGIC CONDITIONS			<input type="checkbox"/> Anti-phospholipid		
<input type="checkbox"/> Migraine Headaches			<input type="checkbox"/> Other:		
<input type="checkbox"/> Seizure Disorder			INFECTIOUS CONDITIONS		
<input type="checkbox"/> Multiple Sclerosis (MS)			<input type="checkbox"/> Cold Sores		
<input type="checkbox"/> Other Conditions:			<input type="checkbox"/> Shingles		
CANCER			<input type="checkbox"/> Hepatitis B		
<input type="checkbox"/> Cancer			<input type="checkbox"/> Hepatitis C		
GENETIC OR CONGENITAL DISORDERS			<input type="checkbox"/> Tuberculosis (TB)		
<input type="checkbox"/> Explain:			<input type="checkbox"/> HIV		
			<input type="checkbox"/> Syphilis		
			<input type="checkbox"/> MRSA Infection		
			<input type="checkbox"/> Other:		

Other SIGNIFICANT Personal Health History:

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

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FAMILY HEALTH HISTORY

ADOPTED—Family History UNKNOWN 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
<input type="checkbox"/> Breast Cancer				
<input type="checkbox"/> Other Breast Condition				
<input type="checkbox"/> Ovarian Cancer				
<input type="checkbox"/> Other Cancers: Colon, Prostate, Lung, Skin				Type:
<input type="checkbox"/> Gynecological Conditions (i.e. Fibroids, etc)				
<input type="checkbox"/> Obstetrical Problems				
<input type="checkbox"/> High Blood Pressure				Medicated
<input type="checkbox"/> High Cholesterol				Medicated
<input type="checkbox"/> Heart Attack				
<input type="checkbox"/> Stroke/TIA				
<input type="checkbox"/> Clotting Disorders				
<input type="checkbox"/> DVT (Deep Vein Thrombosis)				
<input type="checkbox"/> PE (pulmonary embolus)				
<input type="checkbox"/> Thyroid Condition				
<input type="checkbox"/> Diabetes-Type 1 (Juvenile-insulin)				
<input type="checkbox"/> Diabetes-Type 2 (Adult Onset)				Medicated or diet controlled
<input type="checkbox"/> Gestational Diabetes				
<input type="checkbox"/> Anxiety or Depression, other Mental Condition				
<input type="checkbox"/> Neuro Disorder (i.e. MS, Alzheimer's, etc)				
<input type="checkbox"/> Lung Conditions				
<input type="checkbox"/> Stomach, Gallbladder, Liver, Bowel Conditions				
<input type="checkbox"/> Bone/Muscle/Joint Condition (i.e. Osteoporosis, etc)				
<input type="checkbox"/> Kidney or Bladder Condition				
<input type="checkbox"/> Autoimmune Condition (i.e. Lupus, etc)				
<input type="checkbox"/> 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 & CONGENITAL (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 Father was ADOPTED & family history UNKNOWN
 You were ADOPTED: family history KNOWN Father was ADOPTED & family history KNOWN

<input type="checkbox"/> Anencephaly <input type="checkbox"/> Arnold-Chiari Malformation <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Cleft Palate <input type="checkbox"/> Club Foot <input type="checkbox"/> Congenital Heart Defects <input type="checkbox"/> Diaphragmatic Hernia <input type="checkbox"/> Ear or Eye abnormalities <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Hirschsprung's Disease <input type="checkbox"/> Hypospadias <input type="checkbox"/> Limb abnormalities/reductions <input type="checkbox"/> Omphalocele <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Tracheoesophageal Fistula <input type="checkbox"/> Other:	<input type="checkbox"/> Autism <input type="checkbox"/> Canavan's Disease <input type="checkbox"/> Charcot-Marie-Tooth Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Duchenne Muscular Dystrophy <input type="checkbox"/> Fragile X (Mental Retardation) <input type="checkbox"/> Hemophilia <input type="checkbox"/> Huntington's Chorea <input type="checkbox"/> Marfan's Disease <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Phenylketonuria (PKU) <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Sickle Cell Disease or Trait (African American) <input type="checkbox"/> Spinal Muscular Atrophy (SMA) <input type="checkbox"/> Tay-Sachs <input type="checkbox"/> Thalassemia	<p><u>Chromosome Abnormalities</u></p> <input type="checkbox"/> Trisomy 21 (Down Syndrome) <input type="checkbox"/> Trisomy 18 (Edwards Syndrome) <input type="checkbox"/> Trisomy 13 (Patau Syndrome) <input type="checkbox"/> Triploidy <p><u>Sex Chromosomes Abnormalities</u></p> <input type="checkbox"/> Turner's Syndrome (Monosomy X) <input type="checkbox"/> Triple X <input type="checkbox"/> XYY Syndrome <input type="checkbox"/> Klinefelter Syndrome <p><u>Microdeletions</u></p> <input type="checkbox"/> 22q11.2 Deletion Syndrome (DiGeorge) <input type="checkbox"/> 1p36 Deletion Syndrome <input type="checkbox"/> Angelman Syndrome <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Cri-du-chat Syndrome
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NONE known EXPLAIN if a condition was selected from above and who was affected:

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

HEALTH HABITS & SOCIAL HISTORY			
Do you eat undercooked meat or raw sushi?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain: _____	
Do you work with chemicals/radiation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain: _____	
Do you change cat litter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who will do it while you are pregnant?	
Do you exercise on regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain what you do and how often:	
Do you go to the dentist regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Exam Date: _____	
Do you have any physical impairments or handicaps?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain: _____	
Have you experienced any physical, emotional, or sexual abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain: _____	
Do you feel safe in your relationship?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, Explain: _____	
Do you have any major stressors in your life at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain: _____	
Do you have any Religious Beliefs we need to be Aware of?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____