

**PEORIA WOMEN'S HEALTH
OBSTETRICS & GYNECOLOGY**

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PLEASE FILL IN ALL BLANKS AND CIRCLE CORRECT ANSWERS

Date: _____

Name: _____ Date of Birth: _____

Reason for Visit: Annual check-up Pregnancy Other _____

Referred by: _____

of pregnancies _____ # of children _____ # of miscarriages _____

First Day of Last Period _____ Date of Last Pap smear _____

Periods usually last 1, 3, 5, 7 _____ days Year stopped having periods _____

List any serious medical conditions (i.e. heart, kidney problems, diabetes, High blood pressure, etc)

List any operations and the year they occurred:

List any medications you are taking along with dosages

List Family history and relative

Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____

List any medications you are allergic to

Do you have an allergy to latex? Yes No

Do you smoke: Yes No If yes, packs per day _____ #years _____

Do you drink? Yes No If yes, average alcoholic drinks per week _____

Do you use illegal substances? Yes No