

Date _____ Age _____

Family doctor/source of medical care: _____

Reason for visit: _____

Allergies (medications, metals, latex, or anesthesia): _____

Current Medications (include herbs/vitamins/metals): _____

FAMILY HISTORY UPDATE

In the last year, List **ONLY** blood-related parents, brothers and sisters who have had a serious illness including diabetes, heart disease, high blood pressure, breast disease, and cancer? _____

PERSONAL HISTORY UPDATE

Yes	No	In the LAST YEAR, have you had any of the following (Please check)
		A Serious illness, injury, surgery, or hospitalization?
		A Breast Problem (including lump, discharge, surgery, etc)?
		Was your most recent period normal? Day your most recent period began: ____/____/____
		A Sexually Transmitted Infection (chlamydia, gonorrhea, syphilis, herpes, HPV, etc)?
		A problem with your uterus, tubes or ovaries?
		Any problems with your periods (like missed periods or bleeding between periods)?
		A Pregnancy? Date _____ Outcome _____ Total Pregnancies: _____
		If recent pregnancy and delivery, are you currently breastfeeding?
		A new sex partner or more than one sex partner? How long with current partner(s)? _____
		Date of last sexual activity? _____

Yes	No	REPRODUCTIVE LIFE PLAN
		Are you planning a pregnancy in the next year? If no, when? <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 5 years <input type="checkbox"/> Unsure <input type="checkbox"/> Never
		Are you currently using a birth control method? If yes, what method? _____
		Do you have questions about or problems with your method? If yes, what? _____

What Birth control method are you interested in today, if any? _____

Yes	No	SOCIAL HISTORY
		Smoke: # ____ cigarette(s) per day _____
		Alcohol: # ____ drinks per day/week
		Have you ever been a victim of sexual abuse or coercion?
		Have you been hit, hurt or made to feel afraid by an intimate partner, now or in the past?
		Street Drugs: _____

REVIEW OF SYSTEMS

No = no problems with this now

Yes = having problems now

Past = have had this problem in the past

NO	YES	PAST	GENERAL	NO	YES	PAST	RESPIRATORY
			Rapid weight gain or weight loss				Asthma
			Recent weight loss				Tuberculosis (TB)
			Frequent cold, flu, etc.				Chronic cough
			Chronic fatigue >6 months	NO	YES	PAST	GENITOURINARY
			Cancer: _____				Frequent bladder infections
			Genetic condition: _____				Bladder, urinary, or kidney problems
			HIV/AIDS				Abnormality of the uterus/ovaries: _____
NO	YES	PAST	CARDIOVASCULAR				Pelvic pain
			Heart disease/ heart murmur				Pelvic infection/PID
			High blood cholesterol				Vaginal infection/discharge/odor
			Varicose veins				Sores, bumps, rash
			High blood pressure				Endometriosis
			Blood clot in lungs or veins				Other: _____
			Stroke				History of Abnormal Pap Smears? Last Pap? _____
NO	YES	PAST	NEUROLOGIC	NO	YES	PAST	HEMATOLOGIC
			Migraines (diagnosed)				Anemia
			Sensory difficulties (numbness, smell, taste)				Blood clotting disorder
			Seizures/epilepsy/dizziness/fainting				Sickle cell disease
NO	YES	PAST	GASTROINTESTINAL	NO	YES	PAST	ENDOCRINE
			Stomach/bowel problems (constipation, diarrhea, blood in stool)				Diabetes/diabetes in pregnancy
							Thyroid problems
			Liver disease/jaundice/mono	NO	YES	PAST	EYES
			Hepatitis				Eye problems (NOT GLASSES OR CONTACTS)
			Gall bladder disease				
NO	YES	PAST	SKIN	NO	YES	PAST	EARS, NOSE, THROAT, MOUTH
			Acne				Frequent nosebleeds
			Chronic rash or itching				Hearing problems
			Breast: discharge, lump, surgery				Teeth/gum problems
			Other skin problem: _____				Frequent sore throat
NO	YES	PAST	MUSCULOSKELETAL	NO	YES	PAST	PSYCHOLOGIC
			Fractures/broken bones				Anxiety
NO	YES	PAST	AUTOIMMUNE				Depression
			Lupus				Severe mood swings
			Rheumatoid arthritis				Thoughts of suicide
			Fibromyalgia				Any traumatic, painful or emotional event

I acknowledge that the above is correct & complete. If any reportable disease is found, it will be reported to the Health Department.

Client Signature: _____

Date: _____

Complete this section for clients <18 years of age.

- Teen counseling provided (if < age 18). Parental Involvement _____
- STI/Safer Sex/condom use discussed
- Prophylactic ECPs discussed/ requested

Staff Signature: _____

Date: _____

Above Health History Reviewed by:

(Clinician Signature) _____

Date: _____