

AGE: _____

FAMILY HISTORY	MEDICAL HISTORY
<input type="checkbox"/> I am adopted. (Please enter any information you have on your biological family; otherwise proceed to LIFE STYLE and MEDICAL History)	Drug/Medication Allergies (Specify) _____ Other Allergies (Specify) _____
Information about blood relatives only (mother, father, siblings, grandparents) Indicate if a member of your family has any of the following, (relationship and age of onset):	Which of the following do you take regularly: <input type="checkbox"/> None <input type="checkbox"/> Prescriptions <input type="checkbox"/> Over the Counter <input type="checkbox"/> Street Drugs (Please list): _____ _____
<input type="checkbox"/> Heart Disease/Stroke <input type="checkbox"/> Clots in the veins <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High cholesterol/triglycerides <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Other chronic conditions <input type="checkbox"/> Cancer (Breast, ovarian, colon, prostate, other)	Have you ever had surgery or been hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please list) _____
If you were born between 1940 and 1970, did your mother take medication (DES) to keep from losing the pregnancy? <input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know	Have you had any major illnesses, injuries or disabilities? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please list) _____
LIFE STYLE HISTORY	Have you ever had a blood transfusion or other blood exposure? <input type="checkbox"/> No <input type="checkbox"/> Yes
What concerns do you have about your weight? <input type="checkbox"/> None <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Other	Have you had your immunizations (shots), especially MMR? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know
How many times a week do you exercise? _____	Hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know
Do you use seat belts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tetanus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know
What kind of tobacco do you use? <input type="checkbox"/> None Smokeless: Daily _____ Weekly _____ Cigarettes: #/day _____ # years _____	HPV/Gardasil? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ How much? _____	SEXUAL HISTORY
Do you now or have you ever used street drugs or prescription drugs for recreational use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had sex? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, you may skip this section)
Have you ever sought treatment for substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	What types of sex have you had? <input type="checkbox"/> Oral <input type="checkbox"/> Anal <input type="checkbox"/> Vaginal
Do you now or have you ever used IV drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	How old were you when you first had intercourse? _____
CONTRACEPTIVE HISTORY	When did you last have sex? _____
Check all of the birth control methods you have used: ___ Abstinence (not having sex) ___ Pill ___ Sterilization ___ Foam, suppository, gel, film ___ Withdrawal ___ Condoms ___ Diaphragm ___ Depo Provera ___ Norplant / Implanon ___ IUD ___ Sponge ___ Birth Control Patch ___ Vaginal ring ___ Natural Family Planning ___ Other _____	Are you experiencing any pain, discomfort or bleeding with or after intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is the most recent birth control method you have used? _____	Have you had a new sexual partner or more than one sexual partner in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you using this method now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long have you been using it? _____ If no, when did you stop using it? _____	How many sexual partners in your lifetime? _____
Have you had problems with any birth control methods? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe _____	Are/Were your sexual partners: <input type="checkbox"/> men <input type="checkbox"/> women <input type="checkbox"/> both Are/Were your sexual partners: <input type="checkbox"/> IV drug users <input type="checkbox"/> at risk for HIV/STD <input type="checkbox"/> partner with multiple partners <input type="checkbox"/> recently treated for STD
Do you want a birth control method today? <input type="checkbox"/> Yes <input type="checkbox"/> No What method do you think you would like to have? _____	Have you ever been treated for: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Hepatitis B <input type="checkbox"/> N/A When? _____
Does your partner ever sabotage your birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was your partner also treated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your partner pressure you to get pregnant if you don't want to? <input type="checkbox"/> Yes <input type="checkbox"/> No	MENSTRUAL HISTORY
	How old were you when your periods began? _____
	When did your last period start? (date) _____
	Was this period normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Is your period late? <input type="checkbox"/> Yes <input type="checkbox"/> No
	How many days do your periods last? _____ (≥8 days)
	How many days from the start of one period until the start of your next period? _____ (≤20 or ≥36 days)
	How many pads/tampons per day do you use? _____
	Do you bleed between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you noticed a change in your periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have pain with periods or in between? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have irritability, weight gain, backache, or mood changes before or during your period? <input type="checkbox"/> Yes <input type="checkbox"/> No

PREGNANCY HISTORY		SOCIAL INFORMATION	
Do you plan to have children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____		Have you ever been hit, slapped, kicked or verbally abused? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like information about a healthy pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you ever been forced to have sex or perform sexual acts when you didn't want to? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you do not want children, how do you plan to prevent pregnancy? _____		Have you ever been sexually molested? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip this section)		Do you have someone to talk to when you are sad or feel bad? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Age at first pregnancy: _____		Are you currently in an abusive relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been pregnant within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you afraid of your partner or anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of times pregnant: _____ Number of live births: _____		Would you like a referral for counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of living children: _____ Ages: _____		PAP HISTORY	
Number of C-sections: _____ Number of miscarriages: _____		Have you ever had a PAP smear? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip section)	
Number of abortions: _____ Number of ectopic/tubal pregnancies: _____		When was your last Pap smear? _____	
Describe any complication you had during pregnancy (high blood pressure, depression, high blood sugars) _____		What were the results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure	
Are you breastfeeding now? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you ever had an abnormal Pap smear? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you think you may be pregnant now? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when? _____ What was the treatment? _____	

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								
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		
			Liver disease/jaundice/mono						Thyroid problems		
			Hepatitis			NO	YES	PAST	EYES		
			Gall bladder disease						Eye problems (NOT GLASSES OR CONTACTS)		
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		

Is there anything else we should know about you? _____

Client Signature: _____ Date _____

Completed by: _____ Date _____

Reviewed by Health Care Provider: _____ Date _____