

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)		<input type="checkbox"/> Drug/Medication Allergies (Specify) <input type="checkbox"/> 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: (please list) <input type="checkbox"/> Prescriptions <input type="checkbox"/> Over the Counter <input type="checkbox"/> Street Drugs _____	
<input type="checkbox"/> Heart Disease/Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Cancer (Breast, ovarian, colon, prostate, other) <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Other chronic conditions		Have you ever had surgery or been hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please list) _____ Have you had any major illnesses, injuries or disabilities? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please list reasons) _____	
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 your immunizations (shots), especially MMR? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know Hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know Tetanus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know HPV/Gardasil? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know	
LIFE STYLE HISTORY		SEXUAL HISTORY	
What concerns do you have about your weight? <input type="checkbox"/> None <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Other		What are you using to protect yourself from sexually transmitted infections? _____	
What kind of tobacco do you use? <input type="checkbox"/> None <input type="checkbox"/> Smokeless: Daily _____ Weekly _____ <input type="checkbox"/> Cigarettes: #/day _____ # years _____		Are you sexually active now? <input type="checkbox"/> Yes <input type="checkbox"/> No Are your partners? <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ How much? _____		Type of sex? <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral Date of last sex? _____	
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 had a new sexual partner in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever sought treatment for substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has your partner had a new partner in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you now or have you ever used IV drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of partners in the past 12 months? _____	
CONTRACEPTIVE HISTORY		Have you ever had a sexually transmitted infection? If so, please check: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Genital Warts/HPV <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Trichomoniasis <input type="checkbox"/> HIV <input type="checkbox"/> Other	
What birth control method have you used? <input type="checkbox"/> Condoms <input type="checkbox"/> Vasectomy <input type="checkbox"/> None Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Have you ever caused a pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Never tried <input type="checkbox"/> Unsure <input type="checkbox"/> Yes If yes: Number of times: _____ Do you know about ECP? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has your partner been treated for a sexually transmitted infection? If yes, which one? _____	
What method of birth control are you using now? <input type="checkbox"/> Condoms <input type="checkbox"/> Vasectomy <input type="checkbox"/> None <input type="checkbox"/> Partner's When did you last use this method? _____ Have you had sex without birth control or condoms in the last month? <input type="checkbox"/> No <input type="checkbox"/> Yes (dates) _____		Do you have any other questions or concerns about sex that you would like to discuss today? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	
What methods of birth control does your partner use? (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Unsure <input type="checkbox"/> Pills <input type="checkbox"/> Shot (Depo) <input type="checkbox"/> Patch <input type="checkbox"/> Implant <input type="checkbox"/> IUD <input type="checkbox"/> Vaginal Ring <input type="checkbox"/> Female Condom <input type="checkbox"/> Vaginal Spermicide		Have you urinated in the past hour? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Are you circumcised? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Do you do Testicular Self-Exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SOCIAL HISTORY	GENITAL/UROLOGICAL HISTORY (√ all that apply)
Have you ever been hit, slapped, kicked or verbally abused? <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency, pain or burning with urination? <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	Abnormality of the penis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been sexually molested? <input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge from the penis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have someone to talk to when you are sad or feel bad? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you having a problem with this now? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you in an abusive relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores on the penis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like a referral for counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you having a problem with this now? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Sores, lumps, pain or swelling of scrotum? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you having a problem with this now? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Genital trauma or surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Pain or bleeding on ejaculation? <input type="checkbox"/> Yes <input type="checkbox"/> No

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		
			Weight gain or weight loss						Asthma		
			Night sweats						Tuberculosis (TB)		
			Frequent cold, flu, etc.						Chronic cough		
			Chronic fatigue >6 months			NO	YES	PAST	ENDOCRINE		
			Cancer: _____						Diabetes		
			Genetic condition: _____						Thyroid problems		
			HIV/AIDS						Increase in body hair/loss of body hair		
NO	YES	PAST	CARDIOVASCULAR			NO	YES	PAST	HEMATOLOGIC		
			Heart disease/ heart murmur						Swollen glands		
			High blood cholesterol						Blood clotting disorder		
			Stroke						Sickle cell disease		
			High blood pressure			NO	YES	PAST	NEUROLOGIC		
			Blood clot in lungs or veins						Migraines (diagnosed)		
NO	YES	PAST	EYES						Sensory difficulties (numbness, smell, taste)		
			Eye problems (NOT GLASSES OR CONTACTS)						Seizures/epilepsy/dizziness/fainting		
			EARS, NOSE, THROAT, MOUTH			NO	YES	PAST	SKIN		
			Frequent nosebleeds						Acne		
			Hearing problems						Chronic rash or itching		
			Teeth/gum problems						Other skin problem: _____		
			Frequent sore throat			NO	YES	PAST	MUSCULOSKELETAL		
NO	YES	PAST	GASTROINTESTINAL/GENITOURINARY						Fractures/broken bones		
			Stomach/bowel problems (constipation, diarrhea, blood in stool)						Weakness/pain in arms or legs		
			Liver disease/jaundice/mono			NO	YES	PAST	PSYCHOLOGIC		
			Hepatitis						Anxiety		
			Gall bladder disease						Depression		
			Hemorrhoids						Severe mood swings		
			Rectal itching/pain						Thoughts of suicide		
			Rectal discharge						Any traumatic, painful or emotional event		
			Rectal bleeding						Eating disorder (anorexia/bulimia)		
									Anger/abuse issues		

Is there anything else we should know about you? _____

Client Signature: _____

Date: _____

Completed by: _____

Date: _____

Reviewed by Health Care Provider: _____

Date: _____