Name: ____________ D.O.B: ____________ Date: ____________

☐ Yes ☐ No Do you take prescribed medications? List: ____________

☐ Yes ☐ No Are you allergic to any medications? List: ____________

FAMILY HISTORY: Are you adopted? ☐ No ☐ Yes (If yes go to next section.)

Have your parents, brothers, sisters or children had any of the following? If yes, who?

	Yes	No		WHO
1.	☐	☐	Alcohol / drug abuse	
2.	☐	☐	Arthritis	
3.	☐	☐	Severe anemia	
4.	☐	☐	Bleeding problems	
5.	☐	☐	Diabetes	
6.	☐	☐	Cancer: what kind?	
7.	☐	☐	High blood pressure	
8.	☐	☐	Mental illness	
9.	☐	☐	Heart attack	
10.	☐	☐	High cholesterol	
11.	☐	☐	Stroke	
12.	☐	☐	Birth defect/genetic problems (Such as: sickle cell anemia, PKU, Tay Sachs)	

Staff use only

Comments, updates:

MEDICAL HISTORY: Have you had problems with:

	Yes	No	
1.	☐	☐	Allergies: To what?
2.	☐	☐	Skin
3.	☐	☐	Eyes/vision (except glasses)
4.	☐	☐	Ears/hearing
5.	☐	☐	Mouth/teeth
6.	☐	☐	Bleeding or clotting problems (Not with your period)
7.	☐	☐	Anemia
8.	☐	☐	Cancer: what kind?
9.	☐	☐	Diabetes
10.	☐	☐	Thyroid disease
11.	☐	☐	Headaches
12.	☐	☐	Seizures/epilepsy
13.	☐	☐	Psychiatric problems
14.	☐	☐	Suicidal depression
15.	☐	☐	High cholesterol
16.	☐	☐	Heart disease / problem
17.	☐	☐	High blood pressure
18.	☐	☐	Asthma
19.	☐	☐	Tuberculosis
20.	☐	☐	Other lung disease
21.	☐	☐	Positive PPD (skin test for TB)
22.	☐	☐	Breast: lump/tumor/discharge/surgery
23.	☐	☐	Gall bladder or stones
24.	☐	☐	Liver disease/hepatitis/jaundice/mono
25.	☐	☐	Stomach
26	☐	☐	Chicken Pox
27.	☐	☐	Parasites
28.	☐	☐	Ulcer
29.	☐	☐	Black or bloody stools
30.	☐	☐	Kidney
31.	☐	☐	Holding urine / dribbling
32.	☐	☐	Bladder infection
33.	☐	☐	Gonorrhea, syphilis, herpes,warts, Chlamydia
34.	☐	☐	HIV
35.	☐	☐	Bone injuries: broken bones
36.	☐	☐	Back pain
37.	☐	☐	Joint problems: arthritis
38.			Have you ever had shots for the following: ☐ tetanus, diphtheria, partussis ☐ Rubella (German measles) ☐ polio ☐ hepatitis A ☐ hepatitis B

WOMEN

	Yes	No		
38.	☐	☐	Vaginal infection	
39.	☐	☐	Pelvic infection (PID)	
40.	☐	☐	Pelvic tumor/fibroid	
41.	☐	☐	Abnormal pap	Date:
42.	☐	☐	MAMMOGRAM?	Date:

HOSPITALIZATIONS/SURGERIES: **List all (except for pregnancy)**

Year: ______ Reason: ____________ Year: ______ Reason: ____________

Year: ______ Reason: ____________ Year: ______ Reason: ____________

EXPIRE DATE:

Confidential Health History

HABITS & LIFESTYLE: although these questions are personal, they are important to your healthcare.

	Yes	No					
1.	☐	☐	Do you take street drugs?	If so, list: ______			
2.	☐	☐	Do you smoke cigarettes?	If so, # of cigarettes/day:	______	How long?	______
3.	☐	☐	Do you drink alcohol?	If so, # drinks/day:	______	Or # drinks/week:	______
4.	☐	☐	Do you consider yourself to have (had) a problem with drugs or alcohol? Please explain, ______				
5.	☐	☐	Are you working?				
6.	☐	☐	Are you exposed to dangerous chemicals in your work?	If yes, explain ______			
7.	☐	☐	Do you consider your diet healthy?				
8.	☐	☐	Do you ever make yourself vomit after you eat or do you take laxatives to lose weight?				
9.	☐	☐	Do you exercise?	What type?	______	How many times a week?	______
10.	☐	☐	Have you had sex with another person in recent months?				
11.	☐	☐	If you have intercourse, at what age did you begin? ______				
12.	☐	☐	Number of sex partners in the last 6 months? ______	☐ Male	☐ Female	☐ Both	
13.	☐	☐	How often do you use condoms?	☐ Always	☐ Sometimes	☐ Never	
14.	☐	☐	Does your partner have other sexual partner(s)?				
15.	☐	☐	Are you currently, or have you ever been, in a relationship where you were threatened or made to feel afraid?				
16.	☐	☐	Have you ever been hit, kicked, slapped, pushed or shoved by your partner?				
17.	☐	☐	Have you ever been forced or pressured to engage in sexual activity when you did not want to?				
18.	☐	☐	Have you ever been raped?				
19.	☐	☐	What questions do you have about sex? ______				

WOMEN ONLY:

1. MENSTRUAL HISTORY

Age period started:

Periods are:

☐ Regular ☐ Light

☐ Irregular ☐ Moderate

☐ Painful ☐ Heavy

Periods come every _______ Days,

And last _________ Days.

Do you have bleeding between periods?

☐ Yes ☐ No ☐ Sometimes

Is this your first pelvic exam?

☐ Yes ☐ No

2. PREGNANCY HISTORY

Number of:

______ Abortions

______ Miscarriages

______ Still births

______ Cesareans

______ Ectopic pregnancies (tubal)

______ Premature births

______ Normal births

______ Total # of pregnancies

______ Age at first pregnancy

Complications and/or comments on these pregnancies: ______

Date of last pregnancy or birth:

Are you breast feeding? ☐ No ☐ Yes

3. BIRTH CONTROL HISTORY

If you use birth control, what methods have You used?

☐ pills Kind: ______

☐ Depo injection

☐ diaphragm/cervical cap

☐ foam, suppositories, cream, jellies

☐ condoms, rubbers

☐ withdrawal or pulling out

☐ rhythm, calendar, or natural family planning

☐ Norplant

☐ IUD

☐ tubal ligation (sterilization)

☐ None

List any problems with these methods:

______

Current method:

☐ I want to change my method to : ______

______ Client Signature ______ Date

Reviewed by: ______ Clinician/Physician ______ Date

Confidential Health History