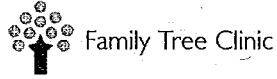


Label Here



Health History Form

Date _____
Clinician _____

Preferred Name: _____ Occupation: _____ Age: _____

Allergies: _____

Medications (including over the counter medications, birth control methods, natural remedies and vitamins): _____

1.) Personal Medical History

Check if you have had any of the following:

- Anemia
- Asthma
- Blood clots (thrombosis)
- Bleeding problems
- Breast lump
- Cancer
- Chemical dependency
- Depression/anxiety
- Eating Disorder
- Heart murmur/disease
- Hepatitis, liver disease
- High blood pressure
- Kidney problem
- Migraine headaches
- Pelvic/testicular infection
- Seizures
- Stomach/bowel problems
- Thyroid problems
- Urinary Tract or bladder infection

2.) Family Medical History

Are you adopted? Yes (if yes, skip to 3) No

If anyone in your biological family has had any of the following, indicate mother (m), father (f), sister (s), brother (b):

- High blood pressure _____
- Heart problems _____
- Blood clotting problems _____
- Osteoporosis _____
- Bleeding problems _____
- Thyroid problems _____
- Diabetes _____
- Stroke _____
- Cancer _____

If yes, what type? _____

Other – please list: _____

Have you ever had surgery?

Yes No If yes, please explain: _____

Have you ever been hospitalized or to the Emergency Room?

Yes No If yes, please explain: _____

3.) General Health

Do you smoke or use tobacco? Yes No

If yes, how much per day? _____

Are you interested in quitting? Yes No

In a typical week, how often do you exercise? _____

In a typical week, how many alcoholic drinks do you have? _____

Do you use recreational/street drugs? Yes No

If yes, how often per week? _____

Have you ever used needles to take drugs? Yes No

Are you being or have you been sexually/physically mistreated? Yes No

Do you want to talk about it? Yes No

Have you been immunized against: Hepatitis B Yes No HPV (Gardasil) Yes No

Where else do you go for medical care? _____

Where do you go for mental health care? _____

Is there anything else you would like us to know? _____

4.) Sexual Health and Family Planning

Do you or your partner want to be pregnant?
Now ___ In the future ___ Never ___ Unsure ___

Are you or your partner currently using a method of birth control? Yes No

If yes, what method? _____

How long have you used this method? _____

Any problems with this method? _____

Check which methods of Birth Control you have ever used:

- Birth Control Pills
- The Patch
- Vaginal Ring (Nuva Ring)
- Spermicide
- Depo (The Shot)
- Diaphragm
- Norplant
- Cervical cap
- Implanon
- Fertility awareness
- IUD
- Cycle Beads
- Tubal ligation
- Withdrawal (Pull-out)
- Condoms
- Vasectomy

Check any of the following you currently have, or have had in the past:

- Chlamydia
- HIV
- Gonorrhea
- Herpes
- Genital Warts/HPV
- Hepatitis B or C
- Syphilis
- Trichomonas
- Other, please list: _____

Have you ever had sexual intercourse? Yes No

Age at first sexual contact _____

How many people have you had sex with in the last 3 months _____ 12 months _____?

Do you have sex with partners who are: (check all that apply)

- Male
- Female
- Transgender
- Other _____

What types of sexual activities do you practice?

- Vaginal
- Oral
- Anal
- Touch with hands
- Sex Toys

What do you do to prevent Sexually Transmitted Infections?

5.) Gynecological and Breast History – answer all that apply to you

Have you ever had a Pap smear? Yes No

When was your last Pap smear? _____

Have you ever had an abnormal Pap smear? Yes No

If yes, please explain: _____

Have you ever had a mammogram? Yes No

Was it normal? Yes No

If no, please explain: _____

Menstrual Cycle

When did your last period start? _____

Was it normal? _____

Periods come every _____ days and last _____ days

Periods are usually:

- light
- moderate
- heavy
- crampy
- irregular

Age periods started _____

Pregnancy History

Are you pregnant now? Yes No Unsure

Have you ever been pregnant? Yes No

How many times? _____

of live births _____ date(s) _____

of abortions _____ date(s) _____

of miscarriages _____ date(s) _____

of ectopic _____ date(s) _____

Any problems with pregnancy or birth? Yes No

If yes, please explain _____

Diabetes in pregnancy? Yes No

For Ages 40 and Over

Check if you have had any of the following:

- Hot flashes
- Trouble sleeping
- Vaginal dryness
- Rapid mood changes
- Urine leaking
- Libido problems
- Other: _____

NOTES: _____

