

Label Here



Date _____
 Clinician _____

Health History Form

Preferred name: _____ Gender pronouns: _____
 Age: _____ Gender Identity: _____ Sex assigned at birth: Female Male
 Occupation: _____
 Allergies: _____ Reaction(s): _____
 Medications (including over the counter medications, birth control methods, herbs, supplements and vitamins):
 Medication: _____ Dosage: _____ Medication: _____ Dosage: _____
 Medication: _____ Dosage: _____ Medication: _____ Dosage: _____
 Medication: _____ Dosage: _____ Medication: _____ Dosage: _____

Personal Medical History

Check if you have had any of the following:

- Anemia
- Anxiety
- Arthritis
- Asthma
- Blood clots or disorders
- Cancer
- Coronary artery disease (heart disease or heart attack)
- Depression
- Diabetes
- Elevated (high) cholesterol
- Gallbladder disease
- GERD (reflux/heartburn)
- Headache, migraines
- Hepatitis/Liver Disease
- Hypertension (high blood pressure)
- Irritable bowel disease
- Osteoporosis
- Renal (kidney) disease
- Seizure disorder
- Stroke
- Thyroid disease
- Breast lump
- Eating disorder
- Chemical dependency
- Urinary tract/bladder infection (UTI)

Other – please list: _____
 Have you ever had surgery? Yes No
If yes, please explain: _____
 Have you ever been hospitalized? Yes No
If yes, please explain: _____

General Health

Do you smoke or use tobacco? Yes No
 If yes, how much per day? _____
 Are you interested in quitting? Yes No
 Do you use e-cigarettes/vaping? Yes No
 Do you drink alcohol? Yes No
 If yes, how many drinks per week? _____
 Do you use recreational/street drugs? Yes No
 If yes, how often per week? _____
 Have you ever used needles to take drugs? Yes No
 If yes, do you share needles? Yes No
 How often do you exercise? _____
 Are you being or have you been sexually or physically mistreated? Yes No
 Do you want to talk about it? Yes No
 Did you receive the following immunizations/vaccines:
 Hepatitis B Yes No
 HPV (Gardasil) Yes No
 Tdap (Tetanus/diphtheria/pertussis) Yes No
 Is there anything else you would like us to know about you or your health? _____

Family Medical History

If you are adopted check here If you do not know any biological family medical history check here

Place and "X" for any relatives with the following:	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Blood Disease/Blood Clots								
Cancer								
Cardiovascular (heart) Disease								
Diabetes								
Genetic Disease								
Hypertension (high blood pressure)								
Osteoporosis								
Stroke								
Thyroid Disease								
OTHER								

Sexual Health and Family Planning

Do you or your partner(s) want to be pregnant?

Now ___ In the future ___ Never ___ Unsure ___

Are you or your partner(s) 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:

- | | |
|---|--|
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> The Patch |
| <input type="checkbox"/> Vaginal Ring (Nuva Ring) | <input type="checkbox"/> Spermicide |
| <input type="checkbox"/> Depo (The Shot) | <input type="checkbox"/> Diaphragm |
| <input type="checkbox"/> Norplant | <input type="checkbox"/> Cervical cap |
| <input type="checkbox"/> Implanon/Nexplanon | <input type="checkbox"/> Fertility awareness |
| <input type="checkbox"/> IUD | <input type="checkbox"/> Cycle Beads |
| <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Withdrawal (Pull-out) |
| <input type="checkbox"/> Condoms | <input type="checkbox"/> Vasectomy |

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? Yes No

If yes, 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 _____

NOTES:

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

- | | |
|--|--|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Genital Warts/HPV | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) |
| <input type="checkbox"/> Trichomonas | |
| <input type="checkbox"/> Other, please list: _____ | |

Have you ever been sexually active? Yes No

Are you currently sexually active? Yes No

What are the gender(s) of your sexual partner(s)?

How many people have you had sex with in the last

3 months _____ 12 months _____?

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 (STIs)?

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

Have you ever had a mammogram? Yes No

Was it normal? Yes No

If no, please explain: _____

Check if you have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Rapid mood changes |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Libido problems |
| <input type="checkbox"/> Urine leaking | |
| <input type="checkbox"/> Other: _____ | |