Label Here

FAMILY TREE CLINIC

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								

OVER

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:

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

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

□ Chlamydia
□ Gonorrhea
□ Genital Warts/HPV
□ Syphilis
□Trichomonas
□ HIV
□ Herpes
□ Hepatitis B or C
□ Pelvic Inflammatory Disease (PID)
□ 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)?
_____
_____

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:
_____
_____
_____
_____
_____
_____
_____
_____

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