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: __________
Medication: __________________ Dosage: __________ Medication: __________________ Dosage: __________

Personal Medical History
Check if you have had any of the following:
□ Anemia                   □ Hepatitis/Liver Disease
□ Anxiety                  □ Hypertension (high blood pressure)
□ Arthritis                □ Irritable bowel disease
□ Blood clots or disorders □ Osteoporosis
□ Cancer                   □ Renal (kidney) disease
□ Coronary artery disease  □ Seizure disorder
(heart disease or heart attack) □ Stroke
□ Depression                □ Thyroid disease
□ Diabetes                  □ Breast lump
□ Elevated (high) cholesterol □ Eating disorder
□ Gallbladder disease       □ Chemical dependency
□ GERD (reflux/heartburn)   □ Urinary tract/bladder infection (UTI)
□ Headache, migraines

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 □

<table>
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<tr>
<th>Place and “X” for any relatives with the following:</th>
<th>Mother</th>
<th>Father</th>
<th>Brother</th>
<th>Sister</th>
<th>Maternal Grandmother</th>
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<td>Blood Disease/Blood Clots</td>
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<td>Hypertension (high blood pressure)</td>
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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 □ The Patch
□ Vaginal Ring (Nuva Ring) □ Spermicide
□ Depo (The Shot) □ Diaphragm
□ Norplant □ Cervical cap
□ Implanon/Nexplanon □ 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 □ Pelvic Inflammatory Disease (PID)
□ Trichomonas
□ 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 □ Trouble sleeping
□ Night sweats □ Rapid mood changes
□ Vaginal dryness □ Libido problems
□ Urine leaking
□ Other:_________________________________________________

Family Tree Clinic ● 1919 Nicollet Avenue, Minneapolis, MN 55403 ● (612) 473-0800