

YOUR SEXUAL HISTORY

Are you currently sexually active: No Yes Age at first intercourse: _____

Number of new sex partners within the past 3 months: _____

More than one sexual partner in the last 12 months: No Yes

Has your partner had more than one sexual partner in the last 12 months: No Yes Unknown

Partners have been: Male Female Both Sites of sexual contact: oral vaginal anal

Does your partner have a history of sex with the same gender: No Yes Unknown

Have any of your partners ever been treated for a sexually transmitted disease: No Yes Unknown

Have you ever been physically or sexually abused or raped: No Yes Date: _____

Was it reported: No Yes Did you receive counseling: No Yes

STD HISTORY

Have you ever had	DATE:	TREATED:		DATE:	TREATED:
HPV/Warts:	_____	_____	Gonorrhea:	_____	_____
Scabies:	_____	_____	Chlamydia:	_____	_____
PID:	_____	_____	Molloscum:	_____	_____
Trich:	_____	_____	Vaginal infections:	_____	_____
Herpes:	_____	_____	Syphilis:	_____	_____

Do you use condoms: No Yes Sometimes Always

PLEASE ANSWER ALL QUESTIONS (Please Circle)

IF MALE please answer

1. History of Penile discharge: Describe:	Y N	5. Do you examine your testes:	Y N	8. Premature ejaculation:	Y N
2. Hernias	Y N	6. Pain in testes/scrotum:	Y N	9. Sexual dysfunction/ impotence:	Y N
3. Prostate problems:	Y N				
4. Have you ever had a P.S.A.:	Y N	7. Mass/lump in testes/ scrotum:	Y N	10. Lesions or bumps: How long:	Y N

IF FEMALE please answer

CONTRACEPTIVE HISTORY

Method today: _____ Sex without contraception (including condom accident) in the last 5 days: No Yes

Prior methods:	DATE:	REASON STOPPED:
<input type="checkbox"/> Pills:	_____	_____
<input type="checkbox"/> Patch:	_____	_____
<input type="checkbox"/> Nuvaring:	_____	_____
<input type="checkbox"/> IUC:	_____	_____
<input type="checkbox"/> Injections:	_____	_____
<input type="checkbox"/> Monthly:	_____	_____
<input type="checkbox"/> Every 3 months:	_____	_____
<input type="checkbox"/> Implants:	_____	_____
<input type="checkbox"/> Condoms:	_____	_____
<input type="checkbox"/> Diaphragm/Cap:	_____	_____
<input type="checkbox"/> Natural Family Planning:	_____	_____

Date: ____/____/____

Patient Name: _____

Patient Number: _____

Date of Birth: _____

IF FEMALE please answer (cont.)

A. Menstrual history: Age of onset:	Age:	H. Abnormal uterus Describe:	Y N	O. Any problems in past Pregnancies Describe:	Y N
B. Are periods regular: Heavy/moderate/light:	Y N H M L	I. History of Vaginal Discharge: Describe:	Y N	P. Are you currently Breastfeeding:	Y N
C. Periods are every: _____ Days and last: _____ days		J. Lesions or bumps How long:	Y N	Q. Last mammogram:	Date
D. Last pelvic exam:	Date	K. Have you ever tried to get pregnant and couldn't:	Y N	R. Sexual dysfunction Describe:	Y N
E. Last PAP:	Date	L. Do you desire pregnancy in the future (WHEN):	Y N	S. Intercourse: Do you have pain and/or bleeding:	Y N
F. Abnormal PAP: Describe:	Y N	M. Total number of pregnancies:	#:		
G. Prior colposcopy/cryo/LEEP/laser/cone: Describe:	Y N	N. Date last pregnancy ended, regardless of outcome:	Date		

Date: ____/____/____

Patient Name: _____

Patient Number: _____

Date of Birth: _____

A. REVIEW OF SYSTEMS:		
Yes	N O	GENERAL
		1. Is your health generally good?
		2. Unexplained weight loss or gain of more than 10 lbs. in the past year?
		3. Night sweats/hot flashes?
		4. Are you being treated for any illness/condition now? If yes what?
		5. Physical/Emotional Abuse?
		6. Coercion/Rape/Incest?
		7. Have you been hit, kicked, punched or otherwise hurt by someone in the past year?
		8. Do you feel safe in your current relationship?
		9. Is there a partner from a previous relationship who is making you feel unsafe now?
		10. Hearing problems?
		11. Frequent nosebleeds?
CARDIO-RESPIRATORY		
		12. Heart disease?
		13. Varicose veins?
		14. Blood clots (head/leg/lungs)?
		15. Stroke or stroke-like problems?
		16. High blood pressure?
		17. High cholesterol?
		18. Chronic cough or other breathing problems/asthma?
		19. Tuberculosis or exposure to tuberculosis?
GASTROINTESTINAL		
		20. Stomach or bowel problems?
		21. Liver problems (hepatitis or tumor, etc.)?
		22. Gallbladder problems?
		23. Rectal Bleeding/pain/itching?
GENITOURINARY		
		24. Bladder, urine leakage or kidney problems
		25. Pain, burning or frequent urination?
		26. Frequent bedtime urination?
		27. Incontinence?
MUSCULOSKELETAL/RHEUMATOLOGICAL		
		28. Arthritis?

		29. Osteoporosis?
		30. SLE (lupus)?
SKIN		
		31. Breast Lump/Discharge?
		32. <input type="checkbox"/> Tattoo? <input type="checkbox"/> Piercing? If yes, where? - _____
NEUROLOGICAL		
		33. Headaches?
		34. Migraine headaches /Aura (diagnosed by MD/NP/PA)?
		35. Seizures/epilepsy?
		36. Numbness in arms/legs (recurring)?
PSYCHOLOGICAL		
		37. Depression requiring treatment? Have you ever considered suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No
		38. Other psychological problems?
ENDOCRINE		
		39. Thyroid problems?
		40. Diabetes?
HEMATOLOGICAL/LYMPHATIC		
		41. Anemia (Low Iron)?
		42. Sickle cell disease/trait?
		43. Blood clotting disorder?
		44. Transfusion of blood/blood products?
IMMUNOLOGIC		
		45. HIV/AIDS?
		46. Cancer?
IMMUNIZATION (Check the ones you have received)		
		47. <input type="checkbox"/> Hepatitis A?
		48. Hepatitis B <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?
		49. Human Papillomavirus (HPV) <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?
		50. <input type="checkbox"/> Measles/Mumps/Rubella (MMR)?
B. HOSPITALIZATION AND SURGERIES		
Year	Reason	
C. ACCIDENTS AND INJURIES		
Year	Reason	

D. FAMILY HISTORY			
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have your biological family (parents, brothers, sisters) had any of the following?			
Yes	N O	Diagnosis	Relative
		Osteoporosis?	
		Diabetes?	
		Heart disease/heart attack/stroke before age 50?	
		High blood cholesterol?	
		Genetic problems?	
		Cancer? If yes, please specify _____	
		Blood clots?	
		Other?	
If you were born before 1972, did your mother take DES NO YES UNKNOWN			
Allergies to: Medications, LATEX, Environment, Food, Other?			
Medications: Including Prescription, over-the-counter, herbals and vitamins:			
		Current:	Past 12 Months:

To the best of my knowledge, the above information is complete and accurate.

Signature of Patient: _____

Signature of Interpreter: _____

Printed Name of Interpreter: _____

Date: ____/____/____

Patient Name: _____

Patient Number: _____

Date of Birth: _____