

Place sticker here

## MEDICAL HISTORY

Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Reason for your visit today \_\_\_\_\_

### Contraceptive History

Check all birth control methods you have used:

- Pill    IUD    Condoms    Sterilization    Diaphragm    Sponge    Foam/Suppository    Patch    Ring    Depo  
 Natural Family Planning (Rhythm)    Withdrawal    Norplant    Other \_\_\_\_\_

**Yes No**

- Do you or your partner use birth control now?  
 If yes, what method(s) do you use? \_\_\_\_\_ How long have you used this method? \_\_\_\_\_  
  Have you had problems with this or any birth control method? If yes explain: \_\_\_\_\_  
  Do you plan to get pregnant in the next year?  
  Do you want a birth control method today? If yes, what method? \_\_\_\_\_

### MENSTRUAL HISTORY

Age periods started \_\_\_\_\_  
 How often do you get your period? \_\_\_\_\_  
 Number of days of flow? \_\_\_\_\_

**Yes No**

- Was your last menstrual period normal?  
  Have you had intercourse (sex) since your last period?  
  Are you concerned that you could be pregnant now?  
  Severe Cramps?  
  Missed periods?  
  Bleeding between periods?

Please describe any problems you have with your period NOW: \_\_\_\_\_

### PREGNANCY HISTORY

- Never Pregnant (skip to next section)  
 Age at first pregnancy: \_\_\_\_\_ Total pregnancies: \_\_\_\_\_  
 1<sup>st</sup> trimester abortions Dates: \_\_\_\_\_  
 2<sup>nd</sup> trimester abortions \_\_\_\_\_  
 miscarriages \_\_\_\_\_  
 still births \_\_\_\_\_  
 caesarean births \_\_\_\_\_  
 ectopic pregnancies (tubal) \_\_\_\_\_  
 premature births \_\_\_\_\_  
 live births \_\_\_\_\_  
 living children \_\_\_\_\_  
 genetic abnormalities \_\_\_\_\_  
 what? \_\_\_\_\_  
 gestational diabetes \_\_\_\_\_  
 Are you breast-feeding?    Yes    No  
 Have you placed a child for adoption?    Yes    No  
 Have you adopted a child?    Yes    No

### SEXUAL HISTORY

Your answers to the following questions will help us assess your risk for cervical cancer and sexually transmitted infections (STIs).

Age at first intercourse: \_\_\_\_\_

**Yes No**

- Are you sexually active now? Check all that apply:    Vaginal    Anal    Oral    Other  
  Have you or your partner had more than one or a new sexual partner in the past year? Are your partners:  
 Male    Female    Both  
  Do you take precautions against sexually transmitted infections? Explain: \_\_\_\_\_  
  Do you feel that any of your partners have put you at risk for sexually transmitted infections or HIV?  
  Are you in a relationship where you are being forced to have sex?  
  Do you have any other questions or concerns about sex that you would like to discuss during the visit?  
 Explain: \_\_\_\_\_

### SOCIAL/ HEALTH RISK HISTORY

**Yes No**

- Do you smoke? How many cigarettes a day? \_\_\_\_\_  
  Do you use alcohol? If yes, how often/how much? \_\_\_\_\_  
  Do you or your partners use street or IV (injectable) drugs?  
  Do you or your partners share needles of any kind?  
  Have you ever had or would you like help now with an alcohol or drug abuse problem?  
  Would you like to discuss problems related to rape or emotional/physical/sexual abuse?  
  Are you now or have you ever been in a relationship where you have been physically hurt or threatened?  
  Do you feel safe at home?  
  Do you use seatbelts?  
  Do you exercise? Activity \_\_\_\_\_  
  Do you have concerns about your weight? Diet? Eating disorder?  
  Are you exposed to work hazards at your place of employment?

Please list any **ALLERGIES**, including drug, metal, latex, skin allergies or irritants, foods

**FAMILY HISTORY**  If you are **ADOPTED**, check and skip to the next section.

Has anyone in your immediate family (father, mother, brother or sister) ever had the following?

- No longer living ( \_\_\_\_\_ )       Breast, Ovarian or Uterine Cancer ( \_\_\_\_\_ )  
 Heart Attack/Heart Disease/Surgery ( \_\_\_\_\_ )       Other Cancer  
 High Blood Cholesterol/High Blood Pressure       Diabetes (Insulin dependent? Yes No)

Women born 1940-1972 - Did your mother take DES (hormones) during her pregnancy with you? Yes No

**PAST MEDICAL HISTORY**

Have you ever had surgery or been a patient in a hospital? Yes No

If yes, describe \_\_\_\_\_

Are you now or have you been, under a doctor's care for a serious illness or condition? Yes No

If yes, describe \_\_\_\_\_

List any and all medications or drugs you are now taking or take often, including over-the-counter medications, herbal medications, and vitamins: \_\_\_\_\_

Do you have another source of health care? Yes No Where? \_\_\_\_\_

**REVIEW OF SYSTEMS** Have you had or do you now have any of the following (please check each item):

**1. General**

Yes No

- My health is generally good  
  Recent weight gain or loss  
  Frequent colds, flu, etc.  
  Chronic fatigue (>6 months)  
  Cancer \_\_\_\_\_  
  Genetic Condition

**2. Immunizations**

- Rubella (German Measles)  
  Vaccine/shot for Rubella/MMR  
  Tetanus Vaccine shot  
  Hepatitis

**3. Cardiovascular**

- Heart Disease/Murmur  
  High Blood Cholesterol/  
Triglycerides  
  High Blood Pressure  
  Thrombophlebitis/Blood clots  
in veins or lungs

**4. Neurologic**

- Stroke  
  Severe Headaches  
  Migraine (Diagnosis by MD)  
  Sensory difficulties (numbness,  
hearing, taste, smell)  
  Seizure/Epilepsy

**5. Gastrointestinal**

Yes No

- Stomach/bowel problems  
  Liver disease/jaundice  
  Hepatitis  
  Gall bladder disease

**6. Endocrine**

- Diabetes/Diabetes of pregnancy  
  Thyroid problems  
  PCOS

**7. Respiratory**

- Asthma  
  Chronic cough  
  Other breathing problems

**8. Genitourinary**

- Abnormal vaginal bleeding/discharge  
  Bladder, urinary or kidney problems  
  Abnormal Pap smear  
  Abnormality of uterus  
  Pelvic Infection/Pain/PID  
  Recurrent vaginal infection  
  Sexually transmitted disease  
Chlamydia/Gonorrhea/Herpes  
Syphilis/Genital warts/HIV/  
Other  
  Breast problems: Discharge/  
Disease/Tumors/Surgery

**9. Hematologic**

Yes No

- Anemia  
  Blood clotting disorder  
  Blood transfusion  
  Sickle Cell Anemia/Trait/Thalassemia

**10. Skin**

- Acne  
  Chronic rash/itching  
  Other skin problems

**11. Musculoskeletal**

- Arthritis  
  Broken bones/fractures

**12. Eyes**

- Eye problems (other than glasses)

**13. Ears, Nose, Throat, Mouth**

- Hearing problems  
  Frequent nosebleeds  
  Frequent sore throat  
  Teeth/Gum problems

**14. Psychology**

- Depression  
  Anxiety  
  Severe moodswings  
  Under care of psychiatrist/  
psychologist

**TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

**Annual Review #1**

No Change  Change (see exam visit form)

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

**Annual Review #2**

No Change  Change (see exam visit form)

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_