

MEDICAL HISTORY - Initial Visit

This medical record is confidential and will not be released to anyone without your written consent except as may be required by law. Please make the clinician aware of any questions you may have regarding the questions on this form.

Name _____ Age: _____ Date of Birth: _____ Today's Date: _____

1. Who is your family doctor or other source of medical care? _____
2. List all allergies to medicines: _____
3. List all medications that you take (prescription and over the counter, include vitamins and supplements): _____

FAMILY HEALTH HISTORY: List ONLY blood-related family members (parents, grandparents, siblings) who have had:

YES NO If yes, please explain.

- 4. I am adopted; my birth family's medical history is unknown. (If yes, skip to question 12)
- 5. Cancer of the Breast, Ovary, Uterus, Colon
- 6. Diabetes
- 7. High Cholesterol or Triglycerides
- 8. High Blood Pressure
- 9. Heart Attack or Stroke before age 50
- 10. Osteoporosis
- 11. If you are older than 30, did your mother take DES while she was pregnant with you?

PERSONAL HEALTH HISTORY: Do you have or have you ever had:

YES NO If yes, please explain.

- 12. High Blood Pressure or Heart Disease?
- 13. A blood transfusion?
- 14. HIV (Human Immunodeficiency Virus)?
- 15. Exposure to blood?
- 16. High Cholesterol or Triglycerides?
- 17. *Migraine* Headaches? (frequent/severe?)
- 18. Strokes/ Blood Clots?
- 19. Seizure Disorder (Epilepsy, Convulsions?)
- 20. Anemia or Low Iron?
- 21. Gall Bladder Disease?
- 22. Anorexia, Bulimia, or other Eating Disorder?
- 23. Psychiatric / Emotional Problems, including Depression?
- 24. Urinary Tract Problems (kidney, bladder, urethra?)
- 25. Thyroid Disease?
- 26. Diabetes?
- 27. Liver Problems (Mono, Jaundice, Hepatitis)?
- 28. Tuberculosis (TB) or exposure to TB?
- 29. Cancer?
- 30. Breast Problems/ Breast Disease?
- 31. Skin allergies or irritants?

YES NO If yes, please explain.

- 32. Serious Illness/ Hospitalization / Surgery?
- 33. Eye Problems?
- 34. Birth defects / Genetic Conditions / Disabilities?
- 35. Dizziness / Numbness?
- 36. Stomach, Intestine, or Bowel Problems?
- 37. Osteoporosis?
- 38. Have you had Rubella or German Measles?
- 39. Have you been vaccinated for Hepatitis B?
- 40. Do you have a current problem with sexual abuse or domestic violence?
- 41. Do you smoke?
How much per day? _____
For how many years? _____
- 42. Do you drink alcohol?
How much per week? _____
- 43. Do you use any other drugs? _____
Explain: _____
- 44. Have you ever used IV drugs? _____

PLEASE TURN OVER

STAFF NOTES

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Name _____ Age: _____ Date of Birth: _____ Today's Date: _____

MENSTRUAL HISTORY

45. Age of first period? _____
46. First day of most recent period? _____
47. Periods come every _____ Days
48. Number of days of flow? _____
49. Number of Pads/Tampons per day? _____
- YES NO If yes, please explain.**
50. Was your last period normal?
51. Do you think you might be pregnant now?
52. Do you ever miss periods?
53. Do you ever bleed between periods?
54. Do you ever have *severe* cramps?
55. Do you ever take medicine for cramps?
Type: _____
56. Do you plan a pregnancy in the next year?
57. Have you ever tried to get pregnant and couldn't?

GYNECOLOGICAL HISTORY

58. Have you ever had sex? YES NO
59. Age at first sex _____
60. Number of sexual partners in last year: _____
Total # of sex partners in your life: _____
61. Have you ever had a pelvic exam? _____
Date of last pap smear _____
- YES NO If yes, please explain.**
62. Have you ever had an infection in your uterus, tubes, or ovaries? (PID)
63. Have you ever had fibroids or cysts?
64. Have you ever had an abnormal pap smear?
65. Have you had any treatment for abnormal pap?
66. Do you have any uterine abnormalities?
67. Do you have pain or bleeding with sexual activity?
68. Problems associated with sexual dysfunction?
69. Do you have *abnormal* discharge or itching?
70. Condom use: Always Sometimes Never
71. Circle if you have ever had:
Gonorrhea Chlamydia Herpes
Syphilis Trichomonas Genital Warts/HPV
- ** Does your sex partner have a history of STIs or HIV?
Explain: _____
72. Are your sexual partners: Male Female Both
73. Sexual contact: None Vaginal Oral Anal

PREGNANCY HISTORY

74. How many times have you been pregnant? _____
75. Age at first pregnancy?
76. List pregnancies (include miscarriages and abortions):
- | Year | Length (weeks) | Outcome (Vag delivery, C-Section, Miscarriage, Abortion, Stillbirth, etc.) |
|-------|----------------|--|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
- Age of Living Children: _____
- YES NO If yes, please explain.**
77. Did you develop Gestational Diabetes?
78. Were there any genetic or birth defects?

CONTRACEPTIVE HISTORY

79. What type of birth control are you using now? _____
80. Circle all birth control methods you have ever used:
- | | | |
|--------------|-----------------|-----------------|
| Condom | Pills | Foam/Spermicide |
| Diaphragm | Sponge | Lunelle |
| Depo Provera | Ortho Evra | Cervical Cap |
| Nuva Ring | IUD | Rhythm Method |
| Withdrawal | Partner Sterile | Self Sterile |
| Norplant | | |
81. Have you had problems with these methods? YES NO
Please describe: _____
82. Are you interested in any birth control method today?
Type: _____

I acknowledge that the above information is correct and complete to the best of my knowledge.

Patient Signature: _____

Date: _____

STAFF NOTES

STAFF SIGNATURE: _____