

Name _____ Date _____

VACCINES

These vaccines are a series of 3 shots, check how many of the shots you have received:

 Hepatitis B 1 shot 2 shots 3 shots

 HPV (Gardasil or Cervarix) 1 shot 2 shots 3 shots

BIRTH CONTROL

 Are you using a birth control method now (including condoms)? No Yes

If Yes, what method: _____

If you want birth control today, which method? (Please circle)

Pills Patch Ring Depo/Shot Condoms Diaphragm

IUD Implanon/Implant Sterilization Fertility Awareness

 Are you planning a pregnancy in the next year? No Yes

 Are you having problems with your current method? No Yes

If Yes, what problem: _____

Other methods used in the past year: _____

 Any problems with your past method: No Yes

If Yes, what problem: _____

MENSTRUAL PERIOD

How old were you when your periods started? _____

 Are you having menopause symptoms or have you gone through menopause? No Yes

 How much time is between each of your periods?
 less than a month about a month more than a month

 My periods are usually: regular irregular

How many days does it usually last? _____

 Is your flow: light moderate heavy
 When was the first day of your last menstrual period? _____

 It was: normal for me not normal for me

PREGNANCY HISTORY
 I have never been pregnant (skip to the next section)

How many: Pregnancies total _____ Living Children _____

Births _____ Miscarriage _____ Abortions _____

Ectopic/Tubal _____ C-Sections _____

 Are you currently breastfeeding? No Yes

Age at first pregnancy: _____ Age at last pregnancy: _____

Have you had problems after childbirth, miscarriage, or abortion?

 If Yes, what: _____ No Yes

SEXUAL HISTORY

These questions may seem personal, but they help us to evaluate your health. All information is confidential.

 Age at first intercourse: _____ Never had intercourse

How many sexual partners have you had in the last year? _____

 Have you had a new partner in the past year? No Yes

 If Yes, new partner in the last 60 days? No Yes

 My partner(s) are: Men only Women only Both

 Does your partner have sex with:
 Men only Women only Both I don't know

 My partner is monogamous (only has sex with you):
 No Yes I don't know

 Is your sexual contact (✓ all that apply):
 Vaginal Anal Oral None Other _____

 Do you use condoms? Always Sometimes Never

 Did you use a condom the last time you had sex? No Yes

 My partner has a sexually transmitted infection (STD):
 No Yes I don't know

 My partner had symptoms of an STD in the last 60 days:
 No Yes I don't know

 Have you ever shared needles (tattoo, piercings, IV drug use, etc.)? No Yes

 My partner uses IV drugs: No Yes

 Did you have a blood transfusion before 1985? No Yes

SUBSTANCE USE

Have you ever used street, recreational or IV drugs? If Yes, what? _____ No Yes

Do you drink alcohol? _____ No Yes
How much per day/week? _____

Do you currently use street, recreational or IV drugs? If Yes, what? _____ No Yes

Do you feel you have a problem with drugs or alcohol? _____ No Yes

Do you use tobacco? No Yes
What type of tobacco? _____
How much per day? _____
For how many years? _____

If Yes, why? _____

LIFESTYLE/CHALLENGES/SUPPORT

Do you have any concerns about your weight or eating habits? No Yes

Do you have a healthy diet? No Yes

Are you being abused sexually, physically, or emotionally? No Yes

Do you exercise regularly? No Yes

Are you being forced to or talked in to doing something against your will? No Yes

Do you work? No Yes

Do you have someone in your life you go to for support? No Yes

If yes: Full time Part time
 Student Other

If Yes, who: _____

ARE YOU HAVING THESE SYMPTOMS NOW OR DO YOU HAVE THEM VERY OFTEN?

No Yes Big change in your weight (more than 25 pounds)

No Yes Bleeding from your rectum

No Yes Fevers, chills, night sweats, or fatigue

No Yes Problems or pain with urination (when you pee)

No Yes Breathing problems, coughing, or shortness of breath

No Yes Abnormal vaginal bleeding, discharge, itching, or sores

No Yes Chest pain

No Yes Pelvic pain, pain with sex or other sexual problems

No Yes Heart palpitations

No Yes Rashes, sores or abnormal bumps on your skin

No Yes Fainting or passing out

No Yes Breast lumps or pain

No Yes Pain in your belly, constipation, diarrhea, or vomiting

No Yes Discharge from the nipple(s)

No Yes Very little interest in activities you used to enjoy

No Yes Dizziness, really bad headaches, changes in your vision

No Yes Feeling depressed

No Yes Intolerance to heat or cold (more than normal)

No Yes Having thoughts of suicide
If YES, are you seeing a therapist?
 No Yes

No Yes Excessive hunger or thirst (more than normal)