

Name _____ Date _____ Pt. # _____

Pregnancy History <input type="checkbox"/> never pregnant										Yes	No	STI/HIV Risks
Delivered					Abortion/Miscarriage							Have you received blood or blood products prior to 1978?
Mo	Yr	Vag	C-Sec	Problems	Yr	Wks	Abort	Mis			Have you ever used street drugs? If yes, when/what?	
											Have you ever shared needles (eg, injecting drugs, tattooing, piercing)?	
											Do you use condoms? <input type="checkbox"/> some of the time <input type="checkbox"/> all of the time <input type="checkbox"/> never	
											Do you have sex with <input type="checkbox"/> men <input type="checkbox"/> women <input type="checkbox"/> both	
											Do you have (check all that apply) <input type="checkbox"/> vaginal <input type="checkbox"/> oral <input type="checkbox"/> anal sex?	
Were there any genetic abnormalities?										Please check all that apply to your present partner(s):		
Contraceptive History										<input type="checkbox"/> past or present use of blood or blood products		
Current birth control method?					How long?					<input type="checkbox"/> use of street drugs		
Any problems with this method? <input type="checkbox"/> yes <input type="checkbox"/> no										<input type="checkbox"/> multiple partners <input type="checkbox"/> bisexual		
If yes, what?										Infected with <input type="checkbox"/> HIV <input type="checkbox"/> STI		
What method do you want to use now?										Age of first vaginal intercourse?		
Are you planning a pregnancy in the NEXT year? <input type="checkbox"/> yes <input type="checkbox"/> no										Any history of sexually transmitted infection?		
Which of the following methods have you used in the past?										<input type="checkbox"/> chlamydia <input type="checkbox"/> gonorrhea <input type="checkbox"/> genital warts <input type="checkbox"/> herpes		
Method					Comment/Problem					<input type="checkbox"/> syphilis <input type="checkbox"/> PID <input type="checkbox"/> HIV/AIDS		
<input type="checkbox"/> Abstinence										Do you have vaginal bleeding after sex? <input type="checkbox"/> yes <input type="checkbox"/> no		
<input type="checkbox"/> Tubal <input type="checkbox"/> Vasectomy <input type="checkbox"/> hysterectomy										How many sexual partners do you have		
<input type="checkbox"/> birth control pill										Now? _____ Past year? _____ Lifetime? _____		
<input type="checkbox"/> the patch										Additional Comments		
<input type="checkbox"/> the ring												
Implant: <input type="checkbox"/> Norplant <input type="checkbox"/> Implanon												
<input type="checkbox"/> Depo-Provera (the shot)												
IUD: <input type="checkbox"/> Mirena <input type="checkbox"/> ParaGard												
Condoms: <input type="checkbox"/> male <input type="checkbox"/> female												
<input type="checkbox"/> Diaphragm <input type="checkbox"/> FemCap <input type="checkbox"/> Lea's Shield												
<input type="checkbox"/> sponge <input type="checkbox"/> spermicide												
<input type="checkbox"/> rhythm												
<input type="checkbox"/> NFP (Natural Family Planning)/FAM												
<input type="checkbox"/> withdrawal												
Yes	No	Reproductive										
		42. Breast lump or nipple discharge?										
		43. Bladder, urine leaks, or kidney problems?										
		44. Uterine fibroids?										
		45. Ovarian cysts?										
		46. Endometriosis?										
		47. If born before 1970, did your mother take DES while pregnant with you?										
		48. Abnormal pap? If yes, when?										
		49. Pain with sex? Other sex problems?										
		50. Vaginal discharge that itches, burns, or has a bad odor? Any sores/bumps?										
Menstrual History										To the best of my knowledge, the information I have provided is correct and complete.		
51. Age periods began?										Client Signature _____ Date _____		
52. Number of pads/tampons used on heaviest day?										Staff Signature _____ Date _____		
53. Length of period? _____ # of days between periods?										History reviewed:		
54. Are your periods usually regular? <input type="checkbox"/> yes <input type="checkbox"/> no												
55. Last period started on: It seemed <input type="checkbox"/> normal <input type="checkbox"/> not normal										Staff Signature _____ Date _____		
56. Do you experience, before or with periods <input type="checkbox"/> severe cramps <input type="checkbox"/> bloating <input type="checkbox"/> bowel problems <input type="checkbox"/> emotional changes												
57. Do you have vaginal bleeding between menstrual periods? <input type="checkbox"/> yes <input type="checkbox"/> no										Staff Signature _____ Date _____		