

**LIMITED SERVICES VISIT HISTORY FORM**

Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Primary phone #: (\_\_\_\_) \_\_\_\_\_  
 Contact address: \_\_\_\_\_  
 Street \_\_\_\_\_  
 \_\_\_\_\_  
 City State Zip

Last/ First Name: _____ Chart#: _____ D.O.B.: _____
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In the event of abnormal test findings, the patient has been advised that a letter may be sent to the above address if PPSWCF is unable to contact by other designated means.

May we contact you by the following means:  Call home  Write home  Call another # \_\_\_\_\_

Person to be contacted in a medical emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

Allergies: \_\_\_\_\_  
 (Including medications, latex, skin allergies, metal allergies)

Hospitalizations: \_\_\_\_\_ Surgeries: \_\_\_\_\_

Major illnesses: \_\_\_\_\_ Injuries: \_\_\_\_\_

Tobacco use: Yes No \_\_\_\_\_/day Alcohol use: Yes No \_\_\_\_\_drinks/week

Recreational drug use: Yes No What kinds and how much: \_\_\_\_\_

Did you mother take DES (a hormone) to prevent miscarriage? Yes No Unknown

Do you have or have you ever had:	Explain:
Cancer: _____ Yes No	_____
Diabetes: _____ Yes No	_____
Heart problems /murmur: _____ Yes No	_____
High blood pressure: _____ Yes No	_____
Thyroid disease: _____ Yes No	_____

Number of pregnancies: \_\_\_\_\_ # deliveries: \_\_\_\_\_ # children: \_\_\_\_\_ # abortions: \_\_\_\_\_ # miscarriages: \_\_\_\_\_

Breast disease /lumps /nipple discharge /surgery Yes No

Lower abdominal pain or pressure: Yes No

Kidney /bladder infections or other problems: Yes No

Uterine growths /fibroids/ abnormalities: Yes No

PID /infection of uterus, tubes, or ovaries: Yes No

When was last Pap: \_\_\_\_\_ Normal or abnormal (circle one)

Pain or bleeding with intercourse: Yes No

Unusual vaginal or penile discharge or odor: Yes No

Itching/ burning/ sores/ rash/ bumps: Yes No

Gonorrhea/ chlamydia/syphilis/herpes/ warts/HIV Yes No

Are you sexually active: Yes No Age at first intercourse: \_\_\_\_\_ How long with current partner: \_\_\_\_\_

Sexual preference:  Male  Female  Both Sexual practices:  Vaginal  Oral  Anal

# of sex partners in your life: \_\_\_\_\_ # of sex partners in past 12 months: \_\_\_\_\_ Birth control method: \_\_\_\_\_

Has your partner(s) been recently treated for STIs or have symptoms? Yes No \_\_\_\_\_

**TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

\_\_\_\_\_ Date: \_\_\_\_\_  
**CA Signature**

\_\_\_\_\_ Date: \_\_\_\_\_  
**Patient signature**

\_\_\_\_\_ Date: \_\_\_\_\_  
**Clinician Signature**

Educational materials provided: