

Preferred Name: \_\_\_\_\_ Date: \_\_\_\_\_

**ALLERGIES**

- Are you allergic to any drug or medication, including anesthesia?  Yes  No  
 Are you allergic to Latex?  Yes  No  
 Are you allergic to Iodine or shellfish?  Yes  No

If you answered yes to any of the above, please write down the medication and type of reaction: \_\_\_\_\_

**MEDICATIONS**

List all medications or drugs you are now taking or take often including prescription medications, birth control, over-the-counter medications, herbal medications, vitamins, minerals, or supplements: \_\_\_\_\_

**PAST MEDICAL HISTORY**

No past medical conditions

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Abnormal PAP*   | <input type="checkbox"/> DES Exposure        | <input type="checkbox"/> Heart problems              | <input type="checkbox"/> Liver disease/tumor*      | <input type="checkbox"/> Syphilis*                          |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Diabetes*           | <input type="checkbox"/> (valvular Hrt disease,      | <input type="checkbox"/> Lupus*                    | <input type="checkbox"/> Thyroid Disease                    |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Drug/Alcohol Abuse  | <input type="checkbox"/> myocardial infraction,      |  | <input type="checkbox"/> Tuberculosis                       |
|  |  | <input type="checkbox"/> heart failure)*             |  |   |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Migraine*                 | <input type="checkbox"/> Urinary Tract Infection, recurrent |
| <input type="checkbox"/> Blood Transfusion                                     | <input type="checkbox"/> Endometriosis       | <input type="checkbox"/> Blood Clotting Disorder     | <input type="checkbox"/> Osteoporosis              |   |
| <input type="checkbox"/> Breast Lump*  | <input type="checkbox"/> Uterine Fibroids    | <input type="checkbox"/> (hypercoagulable disorder)* | <input type="checkbox"/> PID                       | <input type="checkbox"/> Vaginal Infection, recurrent       |
| <input type="checkbox"/> Bleeding Disorder                                     | <input type="checkbox"/> Fracture            |  | <input type="checkbox"/> Polycystic Ovary Syndrome | <input type="checkbox"/> Sickle Cell Anemia*                |
| <input type="checkbox"/> Cancer: type: _____                                   | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> High Cholesterol*           |  | <input type="checkbox"/> Hemoglobin Disorder                |
|  |  |  |  |   |
| <input type="checkbox"/> Stroke (Cerebrovascular accident)*                    | <input type="checkbox"/> Genital Herpes      | <input type="checkbox"/> High Blood Pressure*        | <input type="checkbox"/> Psychiatric               | <input type="checkbox"/> Recurrent Miscarriage              |
| <input type="checkbox"/> Chlamydia   | <input type="checkbox"/> Genital Warts       | <input type="checkbox"/> Infertility                 | <input type="checkbox"/> Blood Clot in Lung        | <input type="checkbox"/> Uterine Anomalies                  |
| <input type="checkbox"/> DVT/Blood Clot in legs*                               | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Inflammatory Bowel Disease  | <input type="checkbox"/> Seizure/Epilepsy*         | <input type="checkbox"/> Enlarged Prostate                  |
| <input type="checkbox"/> Depression*   | <input type="checkbox"/> Hepatitis B         | <input type="checkbox"/> Kidney Failure              | <input type="checkbox"/> Suicide Attempt           |   |
|  |  |  |  |   |
| <input type="checkbox"/> Other Medical Conditions including Genetic conditions | _____  |  |  |   |

Have you ever been hospitalized?  Yes  No Why? \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please list any Surgeries you have had \_\_\_\_\_

**DIAGNOSTIC TEST HISTORY**

- Have you ever had a PAP smear?  Yes  No When? \_\_\_\_\_ Was it normal? \_\_\_\_\_
- If you are over 40 years of age, answer the questions below:**
- Have you ever had a mammogram?  Yes  No When? \_\_\_\_\_ Was it normal? \_\_\_\_\_
- Have you ever had Colon Cancer Screening?  Yes  No When? \_\_\_\_\_ Was it normal? \_\_\_\_\_
- Have you ever had bone density screening?  Yes  No When? \_\_\_\_\_ Was it normal? \_\_\_\_\_
- Have you ever had a Cholesterol Screening?  Yes  No When? \_\_\_\_\_ Was it normal? \_\_\_\_\_
- Have you ever had Diabetes screening?  Yes  No When? \_\_\_\_\_ Was it normal? \_\_\_\_\_
- Have you ever had a Prostate cancer screening?  Yes  No When? \_\_\_\_\_ Was it normal? \_\_\_\_\_

**FAMILY HISTORY**

If you are ADOPTED and do not know your biological family's medical history, SKIP this section.

- |  |            |   |            |
|--|------------|---|------------|
| <input type="checkbox"/> Blood Disease       | who: _____ | <input type="checkbox"/> High Cholesterol*      | who: _____ |
| <input type="checkbox"/> Cancer, type: _____ | who: _____ | <input type="checkbox"/> Osteoporosis           | who: _____ |
| <input type="checkbox"/> Diabetes*           | who: _____ | <input type="checkbox"/> Renal (Kidney) Disease | who: _____ |
| <input type="checkbox"/> Heart Disease       | who: _____ | <input type="checkbox"/> Stroke                 | who: _____ |
| <input type="checkbox"/> High Blood Pressure | who: _____ | <input type="checkbox"/> Other: _____           | who: _____ |

**IMMUNIZATION HISTORY**

Check the immunizations/vaccinations you've had:

- Hepatitis A       HPV       Meningococcal       Tetanus  
 Hepatitis B       MMR/Rubella       Pneumococcal       Varicella  
 Other, please specify: \_\_\_\_\_

**CONTRACEPTIVE HISTORY**

- Are you using a birth control method now?     Yes     No      If yes, what method? \_\_\_\_\_  
 If you want a birth control method today,  
 which method? \_\_\_\_\_  
 Any problems with you current method?     Yes     No      If yes, explain: \_\_\_\_\_  
 Have you had any problems with other birth  
 control methods?     Yes     No      If yes, explain: \_\_\_\_\_  
 Are you or your partner planning a  
 pregnancy in the next year?     Yes     No

**MENSTRUAL HISTORY - Females ONLY**

- No menses yet       Going through menopause now       Post-menopausal: last period \_\_\_\_\_ years ago (skip to next section)  
 How old were you when your periods started? \_\_\_\_\_  
 How often do you get your period?     less than 28 days       every 28 days       more than every 28 days  
 Are your periods:     regular?       irregular?  
 How many days does it usually last? \_\_\_\_\_      Is your flow:     light     moderate     heavy  
 Before your period do you get:     bloating     bowel problems     emotional changes     headache

**PREGNANCY HISTORY - Females ONLY**

- Never been pregnant (skip to the next section)**  
 Total pregnancies \_\_\_\_\_      Births \_\_\_\_\_      Miscarriages \_\_\_\_\_      Abortions \_\_\_\_\_  
 Ectopic/Tubal \_\_\_\_\_      Cesarean sections \_\_\_\_\_      Age at first pregnancy \_\_\_\_\_      Age at last pregnancy \_\_\_\_\_  
 Number of living children \_\_\_\_\_      Are you breastfeeding now?     Yes     No  
 Did you have any problems with or following child birth or abortion?     Yes     No  
 Have you had any of the following problems with pregnancy:  
 Gestational Diabetes       Genetic Abnormalities  
 High Blood Pressure       Preterm Labor

**SEXUAL HISTORY**

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

- Age at first intercourse \_\_\_\_\_       NO intercourse yet  
 How many people have you had sex with in your lifetime? \_\_\_\_\_  
 How many people have you had sex with in the last year? \_\_\_\_\_  
 Have you had sex with someone new in the past year?     Yes     No  
 Are your partners:     Men     Woman     Both  
 Is your partner monogamous (only has sex with you)?     Yes       No       Unknown  
 Does your partner have sex with:     Men       Woman       Both       Unknown  
 Is your sexual contact (check all that apply):  
 Vaginal       Oral       Anal       Other: \_\_\_\_\_  
 Do you use condoms?     Always     Sometimes     Never  
 Have you been exposed to a Sexually Transmitted Infection?     Yes \_\_\_\_\_     No     Unknown  
 Has your partner had any symptoms in the past 60 days?     Yes \_\_\_\_\_     No     Unknown  
 Have you had sex with someone who has other partners, shares needles, or is a man having sex with men?  
 Yes \_\_\_\_\_     No     Unknown  
 Have you ever shared needles (tattoo, IV drug use, etc)?     Yes \_\_\_\_\_     No  
 Did you get a blood transfusion before 1985?     Yes \_\_\_\_\_     No

**SUBSTANCE ABUSE**

- Do you currently use street, recreational or IV drugs?     Yes     No      If so, what? \_\_\_\_\_  
 Do you smoke cigarettes?\*     Yes     No       Not any more      If so, how many/how often? \_\_\_\_\_  
 Do you use other types of tobacco?     Yes     No      If so, what/how often? \_\_\_\_\_  
 Do you drink alcohol?     Yes     No      If so, how many/how often? \_\_\_\_\_  
 Do you feel you have a problem with drugs or alcohol?     Yes     No      Why? \_\_\_\_\_

**LIFESTYLE/CHALLENGES/SUPPORT**

Any recent major life changes?  No  Yes If so, what? \_\_\_\_\_

Any concerns regarding weight or eating?  No  Yes If so, what? \_\_\_\_\_

Are you being abused sexually, physically, or emotionally?  No  Yes If so, explain: \_\_\_\_\_

Are you being coerced to do something against your will?  No  Yes If so, how? \_\_\_\_\_

Do you have a good support system?  No  Yes If so, who? \_\_\_\_\_

Do you eat a healthy diet?  No  Yes

Do you exercise regularly?  No  Yes

Do you work?  No  Yes Full time:  Yes  No Student:  Yes  No

Has anyone ever tried to get you pregnant when you don't want to be?  Yes  No

Has anyone ever made it difficult to use or messed with your birth control?  Yes  No

Does your partner refuse to use condoms when you ask?  Yes  No

**REVIEW OF SYSTEMS**

Check whether you are having any of these symptoms NOW, or have them VERY OFTEN:

**Constitutional**

Yes  No My health is generally good

Yes  No Weight **gain** (unexplained, more than 20% in past year)

Yes  No Weight **loss** (unexplained, more than 20% in past year)

Yes  No Night sweats/hot flashes/fevers/chills

Yes  No Fatigue/lethargy/malaise

**Respiratory**

Yes  No Chronic cough

Yes  No Frequent colds

Yes  No Shortness of breath

**Cardio/Cerebrovascular**

Yes  No Chest Pain

Yes  No Palpitations / irregular heart beat

Yes  No Swelling / edema

Yes  No Syncope / fainting

**Genitourinary - FEMALE ONLY**

Yes  No Urinary pain / dysuria

Yes  No Leaking urine / incontinence

Yes  No Urinary frequency

Yes  No Pain with intercourse or other sexual problems

Yes  No Abnormal Vaginal Bleeding

Yes  No Vaginal discharge

Yes  No Vaginal itching

Yes  No Pelvic pain

Yes  No Painful Periods / Dysmenorrhea

**Genitourinary - MALE ONLY**

Yes  No Urinary pain / Dysuria

Yes  No Leaking urine

Yes  No Urinary frequency

Yes  No Hesitancy

Yes  No Decreased stream

Yes  No Urethral discharge

Yes  No Flank pain

Yes  No Groin pain

Yes  No Testicle pain

Yes  No Quick ejaculation

Yes  No Erectile Dysfunction

Yes  No Lesion/rash

**Gastrointestinal**

Yes  No Abdominal pain

Yes  No Constipation

Yes  No Diarrhea

Yes  No Nausea/vomiting

Yes  No Rectal bleeding

**Skin/Breast**

Yes  No Acne

Yes  No Rash

Yes  No Skin lesion

Yes  No Breast lump

Yes  No Breast pain

Yes  No Nipple discharge

**Endocrine**

Yes  No Cold or heat intolerance

Yes  No Excessive hunger, thirst, or urination

**Neurologic**

Yes  No Dizziness

Yes  No Headache\*

Yes  No Visual disturbance\*

Yes  No Weakness

**Psychiatric**

Yes  No Little interest or pleasure in doing things

Yes  No Feeling down, depressed, or hopeless

Yes  No Feeling suicidal

Yes  No Seeing a therapist or psychiatrist

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

\_\_\_\_\_  
RHS Signature Date

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

Any changes in the past year?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\*These questions are important to evaluate Hormonal Contraception eligibility.