

NAME _____ DATE _____ CHART# _____

SURGICAL HISTORY Have you had any surgery that required hospitalizations? No ___ Yes ___ If yes, please write what type of surgery and what year it was performed _____

FAMILY HISTORY Does anyone in the family have any of the following diseases: no ___ yes ___ if yes, please indicate which people in your family have had the diseases (F) father (M) mother (B) brother (S) sister

Are you adopted? YES ___ NO ___

- _____ Blood clot(s)
- _____ Diabetes
- _____ High Cholesterol (over 300)
- _____ High Blood Pressure
- _____ Stroke, Heart Attack, Heart Disease (age of onset: _____)
- _____ Breast, Ovarian or Uterine Cancer (age of onset: _____)
- _____ Other Cancer
- _____ Osteoporosis (brittle bones)

If you have children under 6 years old, have they been tested for lead poisoning? YES ___ NO ___
Are your children up to date with vaccinations? YES ___ NO ___
(If NO, do you need information on where to go for vaccinations and lead screening? YES ___ NO ___)

SOCIAL HISTORY

- YES NO Please check off below
- ___ ___ Do you smoke? If so, how many cigarettes per day? _____
 - ___ ___ Do you drink alcohol? If so, how often/how much? _____
 - ___ ___ Do you or your partner use street or IV drugs? If so, what? _____
 - ___ ___ Would you like to receive information on where to get help for a drug or alcohol problem?
 - ___ ___ Do you want to discuss problems related to rape, incest or domestic violence?
 - ___ ___ Do you exercise regularly?
 - ___ ___ Do you have concerns about your weight or eating habits that you would like to discuss today?

SEXUAL HISTORY

These questions may seem personal but they help us to evaluate your health. All information is confidential. Please answer only the questions you are comfortable answering.

- YES NO UNKNOWN Please check off below
- ___ ___ ___ Have you had sexual intercourse? Age first time _____
 - ___ ___ ___ Are you currently in a sexual relationship?
Is your sexual contact: all that apply Vaginal Anal Oral
 - ___ ___ ___ Have you had more than one partner in the past year? Are your partner(s) male female both
 - ___ ___ ___ Has your partner had more than one sexual partner in the past year?
 - ___ ___ ___ Has your partner had any bisexual relationships?
 - ___ ___ ___ Do you practice safe sex?
 - ___ ___ ___ Does your partner practice safe sex?
 - ___ ___ ___ Do you want to be tested for sexually transmitted infections and/or HIV?
 - ___ ___ ___ Do you have any questions or concerns about sex that you would like to discuss today?

To the best of my knowledge, the information on this history form is complete and correct.

CLIENT SIGNATURE _____ Date _____

Sign at initial medical visit and annual visit update:

CLINICIAN SIGNATURE _____ Date _____

CLINICIAN SIGNATURE _____ Date _____

CLINICIAN SIGNATURE _____ Date _____

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