CLIENT LABEL

INITIAL HISTORY — COMPREHENSIVE

Date: ____/____/____ Name: _____ Client ID #: _____ D.O.B.:____/____/____ Age: _____

Which pronoun(s) do you prefer? ☐ she ☐ he ☐ other_____

Yes	No	
		1. Do you take any medicine (prescription, over the counter, herbs, vitamins)? If yes, what?
		2. Currently or in the past, have you taken hormones for gender or sex transitioning purposes? If yes, what?
		3. Currently or in the past, have you ever given yourself shots? If yes, what?
		4. Are you allergic to any drugs, medicines, or latex? If yes, what?
		5. Are you using a birth control method? If yes, what? Any problems?
		6. Do you want to change your birth control?
		7. Do you want to get pregnant in the future? If yes, ☐ In the next year ☐ not for awhile ☐ don't know

Yes	No	Have you ever had?
		8. Migraine headache / Aura
		9. Seizures / epilepsy
		10. Thyroid problems
		11. Asthma
		12. Lung disease / TB (tuberculosis)
		13. Heart attack / Heart disease
		14. High cholesterol
		15. High blood pressure
		16. Stroke
		17. Blood clot
		18. Bleeding problem
		19. Anemia (low iron)
		20. Sickle cell disease / trait
		21. Stomach /bowel problems /GERD/hernia/ulcer
		22. Hepatitis / yellow jaundice / liver problems
		23. Gall bladder problems
		24. Bladder, urine leaks, kidney problems
		25. Abnormal Pap test
		26. Did your mother take DES when she was pregnant with you?
		27. Diabetes
		28. Lupus
		29. Breast or Ovarian Cancer
		30. Other Cancer
		31. Lobular carcinoma in situ (LCIS) or atypical hyperplasia of the breast
		32. Chest radiation for treatment of disease
		33. HIV / AIDS
		34. Arthritis
		35. Osteoporosis (weak bones)
		36. Eating disorder / depression / anxiety
		37. Other

Check the immunizations you have received.

38. ☐ Chicken pox ☐ HPV — shot 1, shot 2, shot 3 ☐ Flu
☐ Measles/mumps/rubella (MMR) ☐ Hepatitis A
☐ Tetanus/diphtheria (Td)
☐ Hepatitis B — shot 1, shot 2, shot 3 ☐ Other

39. First day of last period: Age at first period:
Number of days between periods: Length of period:
Do you think your periods are heavy? ☐ yes ☐ no
Any recent changes in your periods? ☐ yes ☐ no

Yes	No	
		40. Have you ever been in the hospital overnight?
		41. Have you ever had surgery?
		42. Are you planning a surgery that will keep you in bed for a long time?
		43. Have you ever used street drugs? If yes, what kind:
		44. Do you use street drugs now? If yes, what kind:
		45. Have you ever smoked? If yes, how long:
		46. Do you smoke now? If yes: How many packs per day? How many years?
		47. Do you drink alcohol? If yes: Drinks/day: Drinks/wk: Type of drink:
		48. Any recent life changes or stresses? If yes, what kind:
		49. Are you worried about your weight or eating habits? If yes, why:
		50. Do you eat a healthy diet?
		51. Do you take calcium?
		52. Do you take vitamin D?
		53. Do you take folic acid?
		54. Do you get regular exercise? If yes, what?
		55. Do you use a seat belt?
		56. Are there any health hazards at home/work/ play? If yes, what:
		57. Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?
		58. Does your partner refuse to use condoms when you ask?
		59. Has your partner ever tried to force or pressure you to become pregnant when you didn't want to be?
		60. Are you afraid your partner will hurt you if you tell him you have an STI and he needs to be treated?
		61. Have you ever been physically or emotionally abused by your partner or someone important to you?
		62. Have you been hit, slapped, kicked or otherwise physically hurt by someone in the past year or, if you're pregnant, since you've been pregnant?
		63. Has anyone forced you to have sex in the past year?
		64. Are you afraid of your partner?

65. Have you ever been pregnant? ☐ yes ☐ no
If yes, how many times: _____
Number of abortions or miscarriages: _____
Number of normal vaginal deliveries: _____
Number of c/sections:_____

66. Have you ever had a complication with a pregnancy or birth?
☐ yes ☐ no If yes, what? ☐ Diabetes ☐ High Blood Pressure ☐ Preeclampsia/Toxemia ☐ Premature Baby ☐ Depression after giving birth ☐ Other

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67. Are you having sex? ☐ yes ☐ no If yes, do you have sex with: ☐ men ☐ women ☐ both ☐ oral ☐ vaginal ☐ anal

68. How many sex partners have you had within the last 12 months? _____

69. Any new sex partners within the past three months? ☐ yes ☐ no

70. Do you use condoms? ☐ always ☐ sometimes ☐ never

71. Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still having sex with you? ☐ yes ☐ no

72. Do you or your partner(s) use IV drugs? ☐ yes ☐ no

73. Have you ever had an STI? ☐ yes ☐ no
If yes, check all that apply: ☐ Chlamydia ☐ Gonorrhea (GC) ☐ Genital Warts ☐ Hepatitis B ☐ Hepatitis C ☐ Herpes ☐ HIV/AIDS ☐ Molluscum ☐ Syphilis ☐ Trichomoniasis (trich)

74. Are you adopted? ☐ yes ☐ no
Do you know your family history? ☐ yes ☐ no

75. Have any of your blood relatives had any of the problems listed below? If yes, please list.

Yes	No	Diagnosis	Relative(s)	How old?
		Diabetes		
		Stroke		
		Heart Disease		
		Blood clots in lungs or legs		
		High blood pressure		
		High cholesterol		
		Hepatitis		
		HIV/AIDS		
		TB		
		Birth Defect		
		Alcohol or drug problems		
		Breast or Ovarian Cancer		
		Other Cancer		
		Mental illness/depression		
		Alzheimer's (dementia)		
		Other		

Yes	No	Have you recently had any of the following?
		76. Lost weight
		77. Gained weight
		78. Felt very, very tired
		79. Gotten shorter

Yes	No	Do you have any of the following now?
		80. Fevers
		81. Trouble sleeping
		82. Frequent headaches
		83. Vision changes / Glasses/Contacts
		84. Earaches / Ringing in ears / Hearing problems
		85. Sinus / sore throat / mouth / teeth problems
		86. Chest pain or pressure
		87. Fast or irregular heartbeat
		88. Trouble breathing with light exercise / when resting
		89. Painful breathing /wheezing / spitting up blood / cough
		90. Problems with bowel movement / gas / nausea /vomiting
		91. Problems with urination
		92. Painful periods
		93. Painful sex
		94. Abnormal vaginal discharge

Yes	No	Do you have any of the following now?
		95. Muscle weakness / muscle or joint pain
		96. Rashes / sores /acne / changes to skin moles
		97. Breast pain / nipple discharge / breast lump
		98. Dizziness
		99. Seizures / numbness
		100. Depression /frequent crying / anxiety
		101. Hair loss
		102. Feeling very hot or cold / hot flashes
		103. More thirst than usual
		104. Frequent bruises / Cuts that don't stop bleeding
		105. Swollen glands
		106. Allergies. If yes, what kind? Reactions?

Staff Comments (do no write anything in this space)

Reviewed and updated history with client.

_____ _____
Staff Signature Date

_____ _____
Staff Signature Date

_____ _____
Staff Signature Date