Staff Use Only: Allergies _____

PERSONAL HISTORY

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent EXCEPT as may be required by law. All clients under the age of 18 are encouraged to talk with their parents about contraception and receiving services.

Date _____ Name _____ Client ID _____ Age _____

I am here today for _____

Questions/concerns I would like to discuss _____

Contraceptive History

Are you currently using birth control? Y N If yes what method? _____
Are you highly satisfied with your birth control method? Y N
Are you having problems with your birth control? Y N If yes what? _____
What other birth control have you used in the past? _____
Why did you stop using the other birth control? _____
What method would you like today? _____

Medical History

Do you have a Doctor/ Clinic that you go to? Yes No Name of doctor/Clinic _____
Are you taking any medications? (prescribed, over the counter, herbal) Yes No What? _____

Do you have any allergies? (Medications, food, latex, metal) List allergies _____
List any hospitalizations, surgery or serious illness in the past year _____
Have you had a blood transfusion before 1984? Yes No If yes, when? _____
Did your mother take DES or medications to prevent miscarriages during the years 1940-1971? Yes No N/A
Are you immunized (had your shots) for:
Rubella (German measles): Yes No Hepatitis B: Yes No Gardasil (HPV): Yes No
How often do you:
Exercise _____ Use Alcohol _____ Use Street Drugs _____
Do you smoke? Yes No
If Yes: What do you smoke? _____ How many a day? _____
How long have you smoked? _____ Do you want to quit? Yes No
Do you feel you eat healthy? Yes No Are you happy with your present weight? Yes No

YES	NO	HAVE YOU HAD	COMMENTS
		Seizures/fainting/Neurological Disorders	
		Emotional Problems/Depression	
		Thyroid Problems	
		Breast Disease/ Lump/ Nipple Discharge	
		Breast or Ovarian Cancer	
		Chest Pain/Difficulty Breathing/Asthma	
		Heart Problems/Murmurs/High Blood Pressure	
		High Cholesterol	
		Blood Clots/Stroke/Varicose Veins	
		Anemia/ Blood Disorders	
		Diabetes	
		Hepatitis, Liver, or Gall Bladder Disease	
		Mononucleosis	
		Stomach/ Intestinal Problems	
		Kidney or Bladder Problems	
		Other Cancer	
		Migraine Headaches with Aura (loss of vision, visual disturbances, weakness of arms/legs, slurred speech) Diagnosed by doctor? Yes No	

FAMILY HISTORY: Have your parents, brothers or sisters ever had any of the following?

Yes	No	Disease	Comments
		Heart Disease or Death from Heart attack before age 50	
		High Blood Pressure	
		Blood Clot/Stroke	
		Anemia/Blood Disorder	
		Diabetes	
		Breast or Ovarian Cancer (any relative)	
		High Cholesterol	
		Genetic Disorders/Birth Defects	
		Other Cancer	

Sexual History

Are you in a sexual relationship? Yes No Age at time you became sexually active
Do you use condoms? Always Occasionally Never
How long have you been sexually active with your current partner? Number of partners in the past year
Has your partner had more than 1 partner in the past year? Yes No
Do you or your partner have STI symptoms? Yes No
Have you or your partner ever been diagnosed with: Gonorrhea Syphilis Chlamydia Herpes HPV/Warts HIV
Have you or your partner been treated for an STI in the past year? Yes No
Have you or your partner used drugs by needles? Yes No
Have you or your partner ever traded sex for drugs or money? Yes No
Who do you have sex with? Males Females Both
Have any of your partners been bisexual? Yes No
Do you feel pressured to have sex? Yes No
Has anyone touched you in a way that made you feel uncomfortable? Yes No
Have you had sex when you didn't want to? Yes No
Do you feel you need to have sex to feel loved? Yes No
Has anyone ever hit or hurt you? Yes No

Females Only

Menstrual History	Gynecological History	Pregnancy history
Age periods began?	Last pap smear? Result?	Do you think you may be Pregnant now? Y N
First day of last period? Month_____ Day_____	Ever had Abnormal Pap Smear? Y N If Yes, when?	Number of Pregnancies? Number of Live Births?
Any unusual/missed periods last year? Y N	Any unusual discharge, odor, itching, sores, rashes or bumps vaginally? Y N	Number of miscarriages? Number of terminations?
How many days do you bleed?	Any pain/bleeding with sex? Y N	Complications with pregnancies? Y N
Do you have severe cramps? Y N	Any pain/burning on urination? Y N	Number of ectopic pregnancies?
Is your bleeding: Light Medium Heavy	Ever diagnosed with pelvic inflammatory disease (PID)? Y N	Are you breastfeeding now? Y N Ages of children?
Any unprotected sex since your last menstrual period? Y N	Diagnosed with uterine growths, fibroids, endometriosis, or other? Y N	Would you like to become pregnant in the next year? Y N

Males Only

Yes	No	Reproductive System	Comments
		Any discharge from your penis or pain/burning on urination? Y N	
		Any pain or lump in testicles? N Y	
		Have you had any treatment for a urological condition? Y N	

To the best of my knowledge, the above information is complete and accurate.

Client Signature: _____ Date: _____

Reviewed By: _____ Date: _____