Medical History

Name _____ Preferred Name _____ Preferred pronouns (he/him, she/her, etc.) _____

Self-declared gender ❑ M ❑ F ❑ NA Are you transgender? ❑ Yes, MTF ❑ Yes, FTM ❑ Yes, Other ❑ No

What is the gender designation on your medical insurance records? ❑ M ❑ F

Reason for today's visit:_____

The following information will help us provide you with the highest quality care.
Please fill out this health history as completely as possible. Thank you.

Medical History *Do you now have or have you had any of the following? Check all that apply.*

❑ Anemia/blood disorder	❑ Sinusitis/allergies	❑ Surgery on reproductive organs
❑ Anesthesia Complications	❑ Frequent headaches	❑ Sickle cell trait
❑ Blood transfusion	❑ Migraine headaches	❑ Cancer
❑ Bleeding problems/blood disease	❑ Muscle or nerve disease	❑ Diabetes
❑ Blood clots in veins	❑ Blurred vision/blackouts	❑ Glaucoma/eye problems
❑ Heart problems/surgery	❑ Epilepsy/seizures	❑ Rheumatic fever
❑ High blood pressure	❑ Fainting	❑ Tuberculosis
❑ Stroke	❑ Hepatitis/liver disease	❑ Alcoholism
❑ Severe varicose veins	❑ Gall bladder problems	❑ Drug addiction
❑ Rhogam injection/Rh negative	❑ Kidney/bladder problems	❑ Depression
❑ Heart murmur	❑ Thyroid disorder	❑ Suicidal thoughts/attempt
❑ Chest pain	❑ Hiatal hernia	❑ Eating disorder
❑ High cholesterol	❑ Ulcer	❑ Panic/anxiety disorder
❑ Nasal polyps	❑ Gastric Bypass surgery	❑ Have you ever been physically assaulted?
❑ Asthma/shortness of breath	❑ Bowel problems	❑ Loose, false or chipped teeth
❑ Bronchitis	❑ Breast problems	❑ Obstructive sleep apnea

Please list any allergies you have, and their reactions: _____

Are you currently taking any medications? Please list any prescriptions, supplements, vitamins or over-the-counter medications:

_____

Do you have or have you had any medical problems? What are they? _____

Are you currently breastfeeding? ❑ yes ❑ no

Family History

Is there a family history of any of the following? If so, please list which family member was affected.

Yes	No	Don't Know	
❑	❑	❑	Are you adopted?
❑	❑	❑	Anesthesia complication
❑	❑	❑	Heart disease
❑	❑	❑	Stroke
❑	❑	❑	Breast or reproductive system cancer
❑	❑	❑	Other cancer Explain: _____
❑	❑	❑	Lupus
❑	❑	❑	Arthritis
❑	❑	❑	Diabetes
❑	❑	❑	Kidney problems
❑	❑	❑	Osteoporosis (brittle bones)
❑	❑	❑	History of inheritable disease (Tay-Sachs, sickle cell anemia, etc.)

Self-identified Ethnicity or Race: _____

(we ask to be able to get grant funding from foundations)

Social History

Yes	No	
❑	❑	Do you exercise regularly? Type and amount per week: _____
❑	❑	Do you use tobacco?
❑	❑	Do you smoke cigarettes? How many per day? _____ How many years have you smoked? _____
❑	❑	Were you previously a smoker?
❑	❑	Do you drink alcohol? How many drinks per week? _____
❑	❑	Do you use drugs for recreation? Please list: _____ How often do you use? _____ times per day/week/month
❑	❑	Is vein access a problem for you?
❑	❑	Do you think you may have a problem with drugs or alcohol?

Would you like referrals or additional information for any of the following?

Yes	No		Yes	No	
❑	❑	Domestic violence	❑	❑	Emergency contraception
❑	❑	Rape/Sexual assault			
❑	❑	Physical abuse	❑	❑	Quitting smoking
❑	❑	Alcohol or drug dependency	❑	❑	Emotional problems

CEDAR RIVER CLINICS

❑ **Renton** ❑ **Tacoma** ☐ **Seattle**

If you are here for a termination...

Do you feel that you have emotional support? ❑ yes ❑ no

How are you feeling about your decision to have an abortion?

❑ Very sure ❑ Sure ❑ Unsure

Current Symptoms

Are you currently experiencing any of the following? How long? Check all that apply.

- ❑ Abdominal pain
- ❑ Lower backache
- ❑ Genital burning
- ❑ Genital itching
- ❑ Unusual discharge
- ❑ Irregular bleeding
- ❑ Pain during or after intercourse
- ❑ Bleeding after intercourse
- ❑ Pain during or after orgasm
- ❑ Rash/bumps/sores in genital area
- ❑ Fever
- ❑ Pain/burning with urination
- ❑ Frequent urination
- ❑ Small amounts of urine
- ❑ Bloody urine

❑ Has your sexual partner had any of the symptoms listed above? Which ones? _____

_____ How long?_____

Reproductive Health History

Do you have or have you had any of the following? Check all that apply.

- ❑ Abnormal Pap smear result
- ❑ Biopsy/colposcopy
- ❑ Laparoscopy/laparotomy
- ❑ Cervical/uterine cancer
- ❑ Cancer: _____
- ❑ Endometriosis
- ❑ Endometritis (infection of the uterus)
- ❑ Vaginal infection
- ❑ Abnormal uterus shape/position
- ❑ Fibroids
- ❑ Pelvic Inflammatory Disease (PID)
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ HPV/genital warts
- ❑ Herpes
- ❑ Syphilis
- ❑ Bacterial vaginosis (BV)
- ❑ Breast lump/cancer
- ❑ Infertility problems
- ❑ Urinary tract infection (UTI)
- ❑ Pre-eclampsia/toxemia
- ❑ Excessive bleeding
- ❑ Date of last Pap smear: _____
- ❑ Have you had the HPV vaccine? How many doses? _____
- ❑ Other_____

Pregnancy History ❑ not applicable

Please list the total number of:

If pregnant, is this your first pregnancy? ❑ yes ❑ no	Pregnancies	Births	Premature Deliveries	Abortions	Miscarriages	Living Children	Cesarean sections	Ectopic	Genetic Defects	

Please explain any pregnancy complication:

Menstrual History ❑ not applicable

Age at first period: _____

Date last period began: _____

Was it a normal period? ❑ yes ❑ no If not, please explain:

_____

_____

Your periods are: ❑ regular ❑ irregular ❑ absent ❑ painful

Your periods come about every _____ weeks for _____ days.

On heavy days, number of pads/tampons used daily: _____

Any recent changes in your menstrual pattern? ❑ yes ❑ no

If so, what changes? _____

_____

_____

Contraceptive History

What, if any, form of birth control are you currently using?

_____

Any problems with it? _____

Do you want to change your method of birth control? If so, which method(s) are you interested in? _____

Have you used any of these contraceptives in the past?

❑ The Pill ❑ Depo Provera ❑ IUD ❑ Male Condom
❑ Female Condom ❑ Foam/Jelly ❑ Sponge ❑ Cervical cap
❑ Diaphragm ❑ Rhythm/Fertility Awareness Method
❑ ECT/Emergency Contraceptive ❑ The Patch ❑ Vaginal Ring
❑ Withdrawal ❑ Implant

Any problems with them? _____

Do you want children in the future? ❑ yes ❑ no ❑ unsure

Sexual History / Orientation

At what age did you first have sexual intercourse? _____

Are you currently having sex? ❑ yes ❑ no

Check all that apply: ❑ vaginal ❑ oral ❑ anal

Do any of your sexual partners have a (check all that apply):
❑ uterus ❑ penis

How many partners have you had in the past 60 days? _____

Has your partner been sexual with anyone else in the last 12 months?
❑Yes ❑Not Sure ❑No

Yes	*No*	*Have you...?*
❑	❑	Had a new sex partner in the last 60 days?
❑	❑	Used a condom the last time you had intercourse?

Additional Information

Emergency Contact:

Please provide the name, relationship to you (i.e. friend, significant other, etc.), and number of your emergency contact:

Name:_____

Relationship to you:_____

Phone number:_____

Can we leave a voicemail at this number if we cannot reach you first:
❑ Yes ❑ No

Preferred Pharmacy:

Name: _____

Address: _____

_____