

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.*

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

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------|
| | <i>Don't</i> | <i>Know</i> | <i>Is there a family history of any of the following?
If so, please list which family member was affected.</i> |
| Yes | No | Know | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you adopted? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anesthesia complication |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast or reproductive system cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other cancer Explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis (brittle bones) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise regularly? Type and amount per week: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke cigarettes? How many per day? _____
How many years have you smoked? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you previously a smoker? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? How many drinks per week? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use drugs for recreation? Please list: _____
_____ |
| | | How often do you use? _____ times per day/week/month |
| <input type="checkbox"/> | <input type="checkbox"/> | Is vein access a problem for you? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you think you may have a problem with drugs or alcohol? |
| <i>Would you like referrals or additional information for any of the following?</i> | | |
| Yes | No | Yes No |
| <input type="checkbox"/> | <input type="checkbox"/> | Domestic violence <input type="checkbox"/> <input type="checkbox"/> Emergency |
| <input type="checkbox"/> | <input type="checkbox"/> | Rape/Sexual assault <input type="checkbox"/> <input type="checkbox"/> contraception |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse <input type="checkbox"/> <input type="checkbox"/> Quitting smoking |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or drug dependency <input type="checkbox"/> <input type="checkbox"/> Emotional problems |

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

CEDAR RIVER CLINICS

- Renton Tacoma Seattle

Current Symptoms

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

- | | | |
|--------------------------------------------|-----------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Irregular bleeding | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Lower backache | <input type="checkbox"/> Pain during or after intercourse | <input type="checkbox"/> Pain/burning with urination |
| <input type="checkbox"/> Genital burning | <input type="checkbox"/> Bleeding after intercourse | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Genital itching | <input type="checkbox"/> Pain during or after orgasm | <input type="checkbox"/> Small amounts of urine |
| <input type="checkbox"/> Unusual discharge | <input type="checkbox"/> Rash/bumps/sores in genital area | <input type="checkbox"/> Bloody urine |

How long? _____

Reproductive Health History

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

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

Please list the total number of:

Pregnancy History not applicable

If pregnant, is this your first pregnancy? <input type="checkbox"/> yes <input type="checkbox"/> 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
 Any problems with them? _____
 Do you want children in the future? yes no unsure

Client Signature

Date

Interpreter Signature

Date

Interpreter Agency

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
 Are your sexual partners male female both
 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?