Medical History

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

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:

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Family History

- Is there a family history of any of the following? If so, please list which family member was affected.
- Are you adopted?
- Anesthesia complication
- Heart disease
- Stroke
- Breast or reproductive system cancer
- Other cancer
- Lupus
- Arthritis
- Diabetes
- Kidney problems
- Osteoporosis (brittle bones)
- History of inheritable disease (Tay-Sachs, sickle cell anemia, etc.)

Social History

- 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
- Would you like referrals or additional information for any of the following?
- Domestic violence
- Rape/Sexual assault
- Physical abuse
- Alcohol or drug dependency
- Emergency contraception
- Quitting smoking
- Emotional problems

Self-identified Ethnicity or Race: (we ask to be able to get grant funding from foundations)

CEDAR RIVER CLINICS
- Renton
- Tacoma
- Seattle
### 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
- Has your sexual partner had any of the symptoms listed above? Which ones? __________________________________________  How long?___________________

- Abdominal pain
- 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
- Pain/burning with urination
- Frequent urination
- Small amounts of urine
- Bloody urine

### Reproductive Health History

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

- Abnormal Pap smear result
- Abnormal uterus shape/position
- Biopsy/colposcopy
- Cervical/uterine cancer
- Cancer: ________________
- Endometriosis
- Endometritis (infection of the uterus)
- Vaginal infection
- Abnormal Pap smear result
- Abnormal uterus shape/position
- Biopsy/colposcopy
- Cervical/uterine cancer
- Cancer: ________________
- Endometriosis
- Endometritis (infection of the uterus)
- Vaginal infection
- Breast lump/cancer
- Infertility problems
- Urinary tract infection (UTI)
- Pre-eclampsia/toxemia
- Excessive bleeding
- Date of last Pap smear: __________
- Other___________________________________________

### Pregnancy History

<table>
<thead>
<tr>
<th>If pregnant, is this your first pregnancy?</th>
<th>Pregnancies</th>
<th>Births</th>
<th>Premature Deliveries</th>
<th>Abortions</th>
<th>Miscarriages</th>
<th>Living Children</th>
<th>Cesarean sections</th>
<th>Ectopic</th>
<th>Genetic Defects</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
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</tbody>
</table>

Please explain any pregnancy complication:

### Menstrual History

- 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

### 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

Have you...?

- Yes  No  Had a new sex partner in the last 60 days?
- Used a condom the last time you had intercourse?