Medical History

Name ______________________________ Preferred Name ____________________________ Preferred pronouns (he/him, she/her, etc.) ________

Self-declared gender ❑ M ❑ F ❑ Nonbinary ❑Other ________________ Sex assigned at birth ❑ F ❑ M ❑ Other________________

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

Yes	No	Don't Know	*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 cancer
❑	❑	❑	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? If no, were you previously a smoker/vaper? ___yes ___no
❑	❑	Do you smoke cigarettes or vape? Cigarettes/vapes per day:_______ Years used:_______
❑	❑	Do you drink alcohol? How many drinks per week? _____
❑	❑	Do you use marijuana? How? ______________________ How often? ____per _____day ____week ____month
❑	❑	Do you use drugs for recreation? Drug type(s): _____________ How often? ____per ____day ____week _____month
❑	❑	Is vein access a problem for you?

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

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:

Pregnancies	Births	Abortions	Miscarriages	Living Children	Cesarean sections	Ectopic

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

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 next 12 months? ❑ 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: ______________________________

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