

# WELLNESS SERVICES – MEDICAL HISTORY – AFAB

Legal name: \_\_\_\_\_ Chosen Name: \_\_\_\_\_ Pronouns (ex: he/she/they/ze): \_\_\_\_\_

Self-declared gender:  F  M  Non-binary  Other \_\_\_\_\_ Gender designation on medical insurance records?  F  M

Self-identified race or ethnicity: \_\_\_\_\_ **MEDICATION ALLERGIES:** \_\_\_\_\_

## MEDICAL HISTORY

### General Medical History (current past)

- Alcohol or substance use disorder
- Anemia/low iron
- Asthma
- Autoimmune disorder: \_\_\_\_\_
- Bleeding disorder
- Blood clotting disorder
- Cancer: \_\_\_\_\_
- Depression and/or anxiety
- Diabetes
- Eating disorder
- Epilepsy/seizures
- Gall bladder problems
- Heart disease: \_\_\_\_\_
- Hepatitis/liver disease
- High blood pressure/hypertension
- High cholesterol
- Hypothyroid/hyperthyroid
- Kidney disease: \_\_\_\_\_
- Lung disease: \_\_\_\_\_
- Migraine headaches
- Obstructive sleep apnea
- Sick cell disease
- Stomach ulcers
- Stroke
- Suicidal thoughts/attempt(s)
- Weight loss medications
- Weight loss surgery
- Other: \_\_\_\_\_

### Reproductive Health History (current or past)

- Abnormal pap smear
- Abnormal uterus shape
- Breast/chest cancer
- Breast/chest mass
- Cervical biopsy/LEEP procedure
- Chlamydia infection
- Endometriosis
- Endometritis (uterine infection)
- Fibroids
- Genital infections (i.e. BV or yeast), frequent
- Gonorrhea infection
- Ovarian cancer
- Pelvic inflammatory disease (PID)
- Polycystic ovarian syndrome
- Postpartum hemorrhage
- Preeclampsia/eclampsia
- Syphilis infection
- Urinary tract infections, frequent (>3 per year)
- Uterine cancer
- Vaginismus

### Preventive Health Screenings

- Date of last Pap smear \_\_\_\_\_  n/a  
 Date of last mammogram \_\_\_\_\_  n/a  
 Have you had the HPV vaccine?  Yes  No  
 If yes, how many doses? \_\_\_\_\_  
 If eligible, are you interested in screening for cervical cancer today?  Yes  No  
 Is **vein access** a problem for you?  Yes  No

### FAMILY Medical History

Do you have a biological family history of the following? *If you do not know your family history, check here  and move to surgical history below:*

- Autoimmune disorder
- Bleeding disorder
- Blood clotting disorder
- Cancer of the  breast/chest  ovary  uterus
- Cancer, other: \_\_\_\_\_
- Diabetes
- Heart disease
- High blood pressure
- High cholesterol
- Inheritable disease (Tay-Sachs, sickle cell, etc.)
- Osteoporosis/hip fracture
- Stroke

### Surgical History

Please list any surgeries you have had:

\_\_\_\_\_

\_\_\_\_\_

### Medications

Please list **all** prescribed and over-the-counter medications you take on a daily or weekly basis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CONTRACEPTIVE HISTORY

Are you currently using something to prevent pregnancy or to manage periods?

- Yes: \_\_\_\_\_  No

Have you used any of the methods below to prevent pregnancy or to manage periods?

- Cervical cap  Condom
- Diaphragm  Emergency pill
- Fertility awareness  Implant
- IUD  Patch
- Pill  Ring
- Shot (Depo)  Sterilization
- Withdrawal

Are you interested in discussing a pregnancy prevention method today?  Yes  No

If yes, what method(s) are you most interested in \_\_\_\_\_

## PREGNANCY AND MENSTRUAL HISTORY

Please list the total number of each below:

Pregnancies (include current)	Births	Abortions	Miscarriages	Living Children	Cesarean Births	Ectopic Pregnancies

Age at first period: \_\_\_\_\_ FIRST day of last period: \_\_\_\_\_

Was your last period normal?  Yes  No: \_\_\_\_\_

Are your periods regular?  Yes: every \_\_\_\_\_ weeks for \_\_\_\_\_ days  
 No: \_\_\_\_\_

Do you have any problems with your period:  Heavy flow  Pain  Mood issues  
 Gender dysphoria  Other: \_\_\_\_\_

Do you want to get pregnant in the next 12 months?  Yes  No  Unsure

**SEXUAL HISTORY**

Do you have any concerns about sex or sexual pleasure?  Yes  No

*If you have never had sex before, check here  and move to next section*

What types of sex do you have?

Vaginal  Oral  Anal  
(check all that apply)

Do any of your sex partners have a penis and testicles?

Yes  No

Have you had a new sex partner in the last 60 days?

Yes  No

Do you or any of your sex partner(s) currently have other sexual partners?

Yes  No  Unsure

Do you use condoms or other barrier methods when having sex?

Yes  No  Unsure

Are you interested in discussing medication to reduce your risk of getting HIV?

Yes  No  Unsure

**SOCIAL HISTORY**

Do you use any of the following substances:

Tobacco, current use  
Cigarettes/vape amount per day: \_\_\_\_\_

Tobacco, past use – quit date: \_\_\_\_\_  
Years of use: \_\_\_\_\_  
Cigarettes/Vape amount per day: \_\_\_\_\_

Alcohol – drinks per week: \_\_\_\_\_

Marijuana –  Smoke  Vape  Edibles  
Amount per week: \_\_\_\_\_

Other drugs/substances, please list: \_\_\_\_\_  
\_\_\_\_\_  
Amount per week: \_\_\_\_\_

Do you have any concerns about nutrition or your relationship to food?  Yes  No

Do you want referrals for any resources today (i.e. intimate partner violence, smoking, substance use, therapy, etc.)?

Yes: \_\_\_\_\_

No

Do you have any safety concerns in your home, community, or workplace?

Yes: \_\_\_\_\_

No

**CONTACT INFORMATION****Emergency Contact**

Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Phone number \_\_\_\_\_

Can we leave a voicemail at this number if we can't reach you first?  Yes  No

**Preferred Pharmacy** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_