

# WELLNESS SERVICES – MEDICAL HISTORY – AMAB

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 or 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
- Sickle cell disease
- Stomach ulcers
- Stroke
- Suicidal thoughts/attempt(s)
- Weight loss surgery
- Other: \_\_\_\_\_

### Reproductive Health History (current or past)

- Breast/chest cancer
- Breast/chest mass
- Chlamydia infection
- Gonorrhea infection
- Painful erections
- Prostate cancer
- Syphilis infection
- Testicular cancer
- Testicular mass
- Undescended testicle
- Urinary tract infection
- Urinary flow difficulties or changes
- Vasectomy

### Preventive Health Screenings

Have you had the HPV vaccine?  Yes  No

If yes, how many doses? \_\_\_\_\_

Have you ever been screened for prostate cancer?

Yes  No

### Surgical History

Please list any surgeries you have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 next section:*

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

### Medications

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SEXUAL & SOCIAL HISTORY

### Sexual History

Do you want to conceive a pregnancy in the next 12 months?

Yes  No  Unsure

If no, do you want to discuss pregnancy prevention?  Yes  No  N/A

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

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

No

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

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: \_\_\_\_\_

\_\_\_\_\_

