04 - 0704

	Y	N	
1.	☐	☒	Are you allergic to any medications? ☐ Tetracycline ☐ Doxycycline ☐ Penici. ☐ Metal ☐ Aspirin ☐ Iodine ☐ Sulfa ☐ Novocaine ☐ Other _____
2.	☐	☒	Are you taking any prescription or nonprescription drugs? List _____
3.	☐	☒	Are you taking any herbal remedies? List _____
4.	☐	☒	Do you take street drugs? Is so, list _____
5.	☐	☒	Have you ever used IV drugs? If so, when _____ What type _____
6.	☐	☒	Do you smoke cigarettes? If so, # of cigarettes per day _____ How long _____
7.	☐	☒	Do you drink alcohol? If so, # of drinks per day _____ or # of drinks per week _____
8.	☐	☒	Do you consider yourself to have (had) a problem with drugs or alcohol? Please explain _____
9.	☐	☒	Have you ever been hit, slapped, or physically hurt by someone? Who _____
10.	☐	☒	Are you currently sexually active?
11.	☐	☐	If you have intercourse at what age did you begin having intercourse? 18
12.	☐	☐	Number of sex partners in last 6 months? 1 ☒ Male ☐ Female ☐ Both
13.	☐	☐	How often do you use condoms? ☒ Always ☐ Sometimes ☐ Never
14.	☐	☒	Have you ever been forced to engage in sex against your will?
15.	☐	☐	What questions do you have about sex? _____

MEDICAL HISTORY Have you ever had any of the following?

	Y	N		Y	N		Y	N	
1.	☐	☒	Visual problems (not glasses)	13.	☐	☒	Bleeding tendency	25.	☐	☒	High cholesterol/blood fat
2.	☐	☒	Epilepsy (Seizures)	14.	☐	☒	Varicose veins	26.	☐	☒	Obesity
3.	☐	☒	Severe headaches	15.	☐	☒	Cancer _____	27.	☐	☒	Gastro-intestinal disorder
4.	☐	☒	Migraine headaches (MD diagnosed)	16.	☐	☒	Hepatitis/Jaundice	28.	☐	☒	Genito-urinary disorder
5.	☐	☒	Stroke	17.	☐	☒	Gall bladder disease	29.	☐	☒	Breast surgery
6.	☐	☒	Coma	18.	☐	☒	Mononucleosis	30.	☐	☒	Kidney disease/infection
7.	☐	☒	Thyroid disease	19.	☐	☒	Pulmonary embolus (blood clot)	31.	☐	☒	3 or more bladder infection
8.	☐	☒	Breast lump	20.	☐	☒	Pulmonary disease	32.	☐	☒	Blood clots in the legs
9	☒	☐	Asthma	21.	☐	☒	Heart murmur	33.	☐	☒	Suicide attempt
10.	☐	☒	Uterine abnormalities	22.	☐	☒	Heart disease	34.	☐	☒	Severe depression
11.	☐	☒	Diabetes	23.	☐	☒	Mitral valve prolapse	35.	☐	☒	Psychiatric problems
12.	☐	☒	Anemia	24.	☐	☒	High blood pressure	36.	☐	☒	Other major illness

GYNECOLOGICAL HISOTRY Have you had any of the following?

	Y	N		Y	N		Y	N	
37.	☐	☒	Abnormal Pap smear	42.	☐	☒	Infertility	46.	☐	☒	Syphilis
38.	☐	☒	Gynecological surgery or procedure	43.	☐	☒	Frequent vaginal infections	47.	☐	☒	Genital warts
39.	☐	☒	Pelvic tumors/fibroids	44.	☐	☒	Chlamydia	48.	☐	☒	Herpes
40.	☐	☒	Infected tubes or uterus (PID)	45.	☐	☒	Gonorrhea	49.	☐	☒	HIV/AIDS
41.	☐	☒	Date of last Pap smear _____ Result ☐ Normal ☐ Abnormal								

FAMILY HISTORY Were you adopted? ☒ Y ☐ N If yes, skip this section.

Have your parents, brothers or sisters had any of the following? If yes, who?

Y	N		Who	Y	N		Who
☐	☐	Diabetes	_____	☐	☐	High blood pressure	_____
☐	☐	Stroke	_____	☐	☐	Breast cancer	_____
☐	☐	Heart attack	_____	☐	☐	Cancer of cervix, uterus and or/or ovary	_____
☐	☐	Did either parent die before the age of 50?	_____	☐	☐	Sickle cell/hereditary diseases	_____

☐ ☐ When your mother was pregnant with you did she have any problems?

☐ ☐ Did she take DES to prevent miscarriage?

Patient Signature _____ Date 01/02/03

Staff Signature _____ Date _____

UPDATED 6/00

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04-07-04

Y N

1. ☐ ☑ Are you allergic to any medications? ☐ Tetracycline ☐ Doxycycline ☐ Penicillin ☐ Metal ☐ Aspirin ☐ Iodine ☐ Sulfa ☐ Novocaine ☐ Other _____
2. ☐ ☑ Are you taking any prescription or nonprescription drugs? List _____
3. ☐ ☑ Are you taking any herbal remedies? List _____
4. ☐ ☑ Do you take street drugs? Is so, list _____
5. ☐ ☑ Have you ever used IV drugs? If so, when _____ What type _____
6. ☐ ☑ Do you smoke cigarettes? If so, # of cigarettes per day _____ How long _____
7. ☐ ☑ Do you drink alcohol? If so, # of drinks per day _____ or # of drinks per week _____
8. ☐ ☑ Do you consider yourself to have (had) a problem with drugs or alcohol? Please explain _____
9. ☐ ☑ Have you ever been hit, slapped, or physically hurt by someone? Who _____
10. ☑ ☐ Are you currently sexually active?
11. ☐ ☐ If you have intercourse at what age did you begin having intercourse? 18
12. ☐ ☐ Number of sex partners in last 6 months? 1 ☑ Male ☐ Female ☐ Both
13. ☐ ☐ How often do you use condoms? ☐ Always ☑ Sometimes ☐ Never
14. ☐ ☑ Have you ever been forced to engage in sex against your will?
15. ☐ ☐ What questions do you have about sex? _____

NKDA

MEDICAL HISTORY Have you ever had any of the following?

Y N

1. ☐ ☑ Visual problems (not glasses)
2. ☐ ☑ Epilepsy (Seizures)
3. ☐ ☑ Severe headaches
4. ☐ ☑ Migraine headaches (MD diagnosed)
5. ☐ ☑ Stroke
6. ☐ ☑ Coma
7. ☐ ☑ Thyroid disease
8. ☐ ☑ Breast lump
9. ☑ ☐ Asthma
10. ☐ ☑ Uterine abnormalities
11. ☐ ☑ Diabetes
12. ☐ ☑ Anemia
13. ☐ ☑ Bleeding tendency
14. ☐ ☑ Varicose veins
15. ☐ ☑ Cancer _____
16. ☐ ☑ Hepatitis/Jaundice
17. ☐ ☑ Gall bladder disease
18. ☐ ☑ Mononucleosis
19. ☐ ☑ Pulmonary embolus (blood clot)
20. ☐ ☑ Pulmonary disease
21. ☐ ☑ Heart murmur
22. ☐ ☑ Heart disease
23. ☐ ☑ Mitral valve prolapse
24. ☐ ☑ High blood pressure
25. ☐ ☑ High cholesterol/blood f
26. ☐ ☑ Obesity
27. ☐ ☑ Gastro-intestinal disord
28. ☐ ☑ Genito-urinary disorder
29. ☐ ☑ Breast surgery
30. ☐ ☑ Kidney disease/infectio
31. ☐ ☑ 3 or more bladder infec
32. ☐ ☑ Blood clots in the legs
33. ☐ ☑ Suicide attempt
34. ☐ ☑ Severe depression
35. ☐ ☑ Psychiatric problems
36. ☐ ☑ Other major illness

4. Albuterol p.r.n.

GYNECOLOGICAL HISOTRY Have you had any of the following?

Y N

37. ☐ ☑ Abnormal Pap smear
38. ☐ ☑ Gynecological surgery or procedure
39. ☐ ☑ Pelvic tumors/fibroids
40. ☐ ☑ Infected tubes or uterus (PID)
41. ☐ ☑ Date of last Pap smear Never Result: ☐ Normal ☐ Abnormal
42. ☐ ☑ Infertility
43. ☐ ☑ Frequent vaginal infections
44. ☐ ☑ Chlamydia
45. ☐ ☑ Gonorrhea
46. ☐ ☑ Syphilis
47. ☐ ☑ Genital warts
48. ☐ ☑ Herpes
49. ☐ ☑ HIV/AIDS

41. Advised yrly paps

FAMILY HISTORY Were you adopted? ☐ Y ☑ N If yes, skip this section.

Have your parents, brothers or sisters had any of the following? If yes, who?

Y N — Who

- ☐ ☑ Diabetes _____
- ☐ ☑ Stroke _____
- ☐ ☑ Heart attack _____
- ☐ ☑ Did either parent die before the age of 50? _____
- ☐ ☑ When your mother was pregnant with you did she have any problems?
- ☐ ☑ Did she take DES to prevent miscarriage?
- ☐ ☑ High blood pressure _____
- ☐ ☑ Breast cancer _____
- ☐ ☑ Cancer of cervix, uterus and or/or ovary _____
- ☐ ☑ Sickle cell/hereditary diseases _____

Patient Signature Carrie Dew Date 5/8/03

Staff Signature L. Moretta Date 5/8/03

04-07-4

Name: Sapna Dev Birthdate: / /

...ABITS & LIFESTYLE: although these questions are personal, they are important to your healthcare. If you prefer, you can talk to your clinician about them.

	Y	N		
1.	☐	☒	Do you smoke cigarettes?	If so, # of cigarettes/day: _____ For how long? _____
2.	☐	☒	Do you drink alcohol?	If so, # drinks/day: _____ or, # drinks/week _____
3.	☐	☒	Do you take street drugs?	If so, list: _____
4.	☐	☒	Do you think you have (had) a problem with drugs or alcohol?	
5.	☐	☒	Are you working?	
6.	☒	☐	Is your diet (what you eat) healthy?	
7.	☐	☒	Do you ever make yourself vomit after you eat or take laxatives to lose weight?	
8.	☒	☐	Do you exercise? What type? Running	How many times a week? Couple
9.			If you have intercourse, at what age did you first have intercourse? _____	
10.	☒	☐	Have you had sex with another person in recent months? Check all that apply: ☒ Vaginal ☐ Anal ☒ Oral ☐ Other: _____	
11.	☐	☒	Have you had more than one partner or a new partner in the last year?	
12.	☒	☐	Do you have sex with men?	
13.	☐	☐	Do you have sex with women?	
14.			How often do you use condoms? ☒ Always ☐ Usually ☐ Sometimes ☐ Never	
15.	☐	☒	Does your partner have other sexual partner(s) or share needles?	
16.	☐	☒	Are you now, or have you ever been, in a relationship where you were threatened or made to feel afraid?	
17.	☐	☒	Have you ever been hit, kicked, slapped, pushed or shoved by your partner?	
18.	☐	☒	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?	
).	☐	☒	Do you have questions or concerns about sex that you would like to discuss?	

Staff use only
comments, updates:

WOMEN ONLY:

1. Menstrual History

Age period started: 15
Periods are:
☒ regular ☐ light
☐ irregular ☒ moderate
☐ painful ☐ heavy

Periods come every 30 days, and last 4-5 days.

Do you have bleeding-between periods?
☐ Yes ☒ No ☐ Sometimes

Is this your first pelvic exam?
☒ Yes ☐ No

2. Pregnancy History

Number of:
_____ abortions
_____ miscarriages
_____ still births
_____ cesareans
_____ ectopic pregnancies (tubal)
_____ premature births
_____ normal births

_____ Total number of pregnancies
_____ Age at first pregnancy

Complications and/or comments on these pregnancies:

Date of last pregnancy or birth:

Are you breast feeding?
☐ Yes ☐ No

3. Birth Control History

If you use birth control, what methods have you used?
☐ pills Kind: _____
☐ Depo Provera/Lunelle Injection
☐ Norplant
☐ IUD
☐ diaphragm/cervical cap
☐ foam, suppositories, cream, jellies
☐ condoms, rubbers
☐ withdrawal or pulling out
☐ rhythm, calendar, or natural family planning
☐ tubal ligation (sterilization)
☐ Other: _____
☐ None
List any problems with these methods:

Current method: _____
☐ I want to change my method to _____

Sapna Dev 11/05/03
Client Signature Date

Reviewed by: [signature] 11/5/03
Clinician/Physician Date

Update: _____
Clinician/Physician Date

Update: _____
Clinician/Physician Date

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