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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