| Name: |
| --- |
| Today’s date: |
| Birth Date: Age: |
| Primary Care Provider: |
| List any prescriptions or over the counter medicines you are taking now |
| List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Your Medical History** | | | |
| **Yes** | **No** | **Do you have now or have you had any of the following?** | **Staff Comments** |
|  |  | Have you been to the ER or hospitalized in the last year? |  |
|  |  | Surgery - List type and date: |  |
|  |  | Cancer: What type? When? |  |
| **Ears/Nose/Mouth/Throat/Eyes** | | | |
|  |  | Eye problems (except glasses or contacts) |  |
|  |  | Hearing problems |  |
| **Cardiovascular** | | | |
|  |  | Heart disease, murmur, high blood pressure |  |
|  |  | High cholesterol/triglycerides |  |
|  |  | Blood clots in arms/legs/chest |  |
|  |  | Heart attack or stroke |  |
| **Respiratory/Upper Body** | | | |
|  |  | Breathing problems or Asthma |  |
|  |  | Breast lumps or nipple discharge |  |
|  |  | Mammogram and/or breast ultrasound Date: |  |
|  |  | Tuberculosis or exposure to tuberculosis |  |
| **Gastrointestinal** | | | |
|  |  | Stomach or bowel problems |  |
|  |  | Gall bladder disease |  |
|  |  | Liver disease (hepatitis, mono, jaundice, cirrhosis) |  |
| **Genitourinary** | | | |
|  |  | Kidney or bladder problems |  |
|  |  | Burning urination and/or blood in urine |  |
| **Musculoskeletal** | | | |
|  |  | Arthritis or osteoporosis |  |
|  |  | Gout |  |
| **Skin** | | | |
|  |  | Acne or other skin problems – Please specify: |  |
|  |  | **Endocrine** |  |
|  |  | Thyroid problems |  |
|  |  | Diabetes |  |
| **Neurological** | | | |
|  |  | Migraines or frequent headaches |  |
|  |  | Epilepsy or convulsions |  |
| **Hematological/Lymphatic** | | | |
|  |  | Blood problems (Sickle cell anemia, hemophilia, low iron) |  |
|  |  | Have you or your partner(s) ever had a blood transfusion, tissue/organ transplant or artificial insemination? |  |

| **Your Medical History (Continued)** | | | |
| --- | --- | --- | --- |
| **Yes** | **No** | **Do you have now or have you had any of the following?** | **Staff Comments** |
| **Psychological** | | | |
|  |  | Depression or emotional problems |  |

| **Your Family History**  Please check here if you don’t know your family history. | | | |
| --- | --- | --- | --- |
| **Yes** | **No** | **Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.** | **Staff Comments** |
|  |  | Blood clots in arms/legs/chest |  |
|  |  | Bleeding problems ­­­­­­­­­­ |  |
|  |  | High blood pressure |  |
|  |  | High cholesterol/triglycerides |  |
|  |  | Breast/ovarian/uterine/colon cancer |  |
|  |  | Heart attack |  |
|  |  | Stroke |  |
|  |  | Diabetes |  |
|  |  | Birth defects/genetic disorders |  |
|  |  | Alcohol/drug abuse |  |
|  |  | Mental health disorders |  |
|  |  | Physical or sexual abuse |  |

| **Your Personal History** | | | |
| --- | --- | --- | --- |
| **Yes** | **No** |  | **Staff Comments** |
|  |  | Have you had the HPV vaccine series |  |
|  |  | Do you smoke tobacco?  Everyday Somedays Former Smoker  Never smoked |  |
|  |  | Do you drink alcohol? How many drinks per day? \_\_\_\_\_ per week? \_\_\_\_\_\_\_\_ |  |
|  |  | Do you use marijuana or marijuana products? How often? |  |
|  |  | In the past year, have you used an illegal drug or a prescription drug for non-medical reasons? |  |
|  |  | Do you vape, chew, or use any form of a nicotine delivery system other than smoking? |  |
|  |  | Do you exercise? How often? |  |
|  |  | Do you use caffeine? How often? |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | How often are you around people who regularly use tobacco, alcohol, or drugs? |  |
|  | |  | Have you ever been hit, slapped, kicked, shaken or hurt by anyone? |  |
|  | |  | Have you ever been forced to have sex? |  |
|  | |  | Is there anyone who makes you feel unsafe now? |  |
|  | |  | When was the last time you were out of the country? |  |
|  | |  | Have you had tetanus, diptheria, pertussis (Td/Tdap) vaccine? When? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Your Sexual History** | | | |
| **Yes** | **No** | **Have you ever had any of the following sexually transmitted infections:** | **Staff Comments** |
|  |  | Chlamydia |  |
|  |  | Gonorrhea |  |
|  |  | Genital warts/Human Papillomavirus (HPV) |  |
|  |  | Syphilis |  |
|  |  | Herpes |  |
|  |  | Trichomoniasis |  |
|  |  | Non-gonococcal urethritis (NGU) |  |
|  |  | Have you or your sexual partner(s) ever used needles for drugs (to shoot drugs)? |  |
|  |  | Have you or your sexual partner(s) ever exchanged sex for drugs or money? |  |
|  |  | Do you use condoms?  Never  Sometimes  Always |  |
|  |  | Have you had HIV testing? When? |  |
|  |  | Was the HIV test positive (HIV infection found)? |  |
|  |  | Have you had a new partner in the past 2 months? |  |
|  |  | Does your sex partner have other partners? |  |
| 1. How many sexual partners have you had in the past 2 months?  2. How many sexual partners have you had in the past year?  3. Are your sex partners:  male  female  both  transman  transwoman  intersex  other  4. Do you have:  Vaginal sex  Oral sex  Anal sex  5. When was the last time you had sex?  6. Have any of your male partners had sex with other men?  Yes  No  Not Sure  N/A  7. Are any of your sex partners living with HIV?  Yes  No | | | |

| **(Male/Assigned male at birth/MTF)** | | |
| --- | --- | --- |
| **Your Urological History** | | |
| **Yes** | **No** |  |
|  |  | Do you have abnormal discharge from the penis now? |
|  |  | Do you have now or in the past a lesion, sore, or lump on your penis? Describe:  When? |
|  |  | Do you have now or had in the past a lesion, sore, or lump on your scrotum or testicles?  Describe: When? |
|  |  | Have you ever had pain during sex? When? |
|  |  | Have you had gender affirming surgery? If so, describe: |
| **Your Reproductive History** | | |
|  |  | Do you have any children? How many? |
|  |  | Do you plan to have children? When?  Now  1-2 Years  3-5 Years  5+ Years  Unsure |
|  |  | Are you using birth control?  Please check the birth control method(s) you use:  Condoms Vasectomy  Rely on partner’s method. What method does your partner use? |

| **(Female/Assigned female at birth/FTM)** | | |
| --- | --- | --- |
| **Yes** | **No** |  |
|  |  | Do you plan to have children? When?  Now  1-2 Years  3-5 Years  5+ Years  Unsure |
| **Your Menstrual History** | | |
| Date of the first day of your last menstrual period: | | |
| **Yes** | **No** |  |
|  |  | Was your last menstrual period normal?  If not, explain: |
|  |  | Do you have a period every month?  Is the flow:  light  medium  heavy |
|  |  | Do you bleed between periods? |
|  |  | Do you have cramps with your periods? |
|  |  | Do you take medication for cramps?  Over the counter  Prescription medication |
| How old were you when you had your first period? | | |
| **Your Pregnancy History** | | |
| How many times have you been pregnant?  How many miscarriages have you had?  How many abortions have you had?­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many tubal pregnancies have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many living children do you have? Has it been more than 21 days since your last delivery? \_\_\_\_\_\_\_\_\_\_  List the dates of any tubal pregnancies:  Are you breast-feeding now?  Yes  No | | |
| **Your Gynecological History**  Have you ever had a Pap test? Yes  No | | |
| When was your last Pap test done?Month Year | | |
| **Yes** | **No** | **Have you had any of the following?** |
|  |  | Abnormal Pap test. If yes, when? |
|  |  | Treatment for abnormal pap |
|  |  | Ovary problems |
|  |  | Uterus problems or uterine fibroids |
|  |  | Pelvic Inflammatory Disease (PID) |
|  |  | Pain or other problems with sex |
|  |  | Vaginal discharge that itches/burns or has a bad odor |
|  |  | Have you had gender affirming surgery? If so, describe: |
| **Your Birth Control History** | | |
| **Yes** | **No** |  |
|  |  | Are you using a method of birth control now? If yes, what method? |
|  |  | Have you used any birth control methods that you have had a problem with?  What method/s? |
|  |  | In the last 5 days or since your last period, have you had sex without birth control? (condoms are birth control) |