Client Name____**Age**___ **DOB**___/____/_____

Reason for today's visit: ____

Allergies:____

General Health

Have you ever had or do you have:

Yes	No		Yes	No	
□	□	Diabetes/ Thyroid Problems	□	□	Problems with your kidneys or bladder
□	□	Seizures	□	□	Cancer ________________________
□	□	Heart attacks or strokes	□	□	High blood pressure
□	□	Breast surgery or problems	□	□	Hepatitis (skin turned yellow) or gallbladder problems
□	□	Depression	□	□	Pelvic infection treated in the hospital
□	□	Migraines with aura	□	□	Uterine fibroids or ovarian cysts
□	□	Blood Clots in your blood vessels like leg or lung	□	□	Problems with vision or hearing
□	□	Blood transfusions	□	□	Eczema or skin problems
□	□	Shortness of breath	□	□	Problems with muscles / bones
□	□	Anemia	□	□	High Cholesterol

□ □ Other medical conditions, any surgery or been hospitalized? If yes explain…

____

How many times a week do you exercise? _____ Per day, how many fruits___ vegetables____ dairy_____ grains____ meat ________ do you eat?

Do you chew / smoke tobacco? ___No ___Yes If yes how many cigarettes a day? ____ How long have you chewed / smoked? ______________

How many alcoholic beverages do you drink per day___, week___, month___? Are you worried about your alcohol use? ___No ___Yes

Do you currently use street drugs? ___No ___Yes If yes how many times a week?____

Do you or have you used injectable drugs? ___No ___Yes If yes, how often?____ Last time used? ______________________

List the medications you are taking, how often and how much. Include prescriptions, over the counter (Ibuprofen, Tylenol), herbs, & vitamins:

____

The date of last mammogram____________ Results ______________ If age 50 or older, have you had colon cancer screening? ___No ___Yes

Immunizations

Please give the date of your last immunizations. (A tetanus booster dose is recommended every 10 years.)

_____MMR (1 or 2 doses) _____Td/Tdap _____Hepatitis B, series _____HPV vaccination Other, list___________

Family History

Have any of your blood relatives had the following conditions?

Include your mother, father, brothers, and sisters

Yes	No	Whom	
□	□	_______	Diabetes
□	□	_______	Cancer (type) ____________
□	□	_______	Blood clots
□	□	_______	High Blood Pressure
□	□	_______	High Cholesterol
□	□	_______	Stroke
□	□	_______	Sickle Cell
□	□	_______	Heart Disease or Heart Attack

Psychosocial:

Do you have any concerns regarding the following…

If yes, please explain

Yes	No	
□	□	Relationships ________________
□	□	Financial_____________________
□	□	Work _______________________
□	□	School ______________________

Menstrual

Age of first period ________ Date of last period (1st day) __________

Length of period__________

Yes	No	
□	□	Overdue period
□	□	Painful periods
□	□	Spotting between periods
□	□	Menstrual Tension
□	□	Menstrual Weight gain
□	□	Backache during period
□	□	Mood changes before period
□	□	Is this your first Pap Smear?
□	□	Shortness of breath
□	□	Anemia

Pap Smears

Last Pap__________ Where done ___________

Results: __Normal __Abnormal __ Unknown

Pap History:

Yes	No	
□	□	Abnormal Pap
□	□	Colposcopy
□	□	LEEP procedure
□	□	Other: ______________

Pregnancy

# Pregnancies		Pregnancy Complications	
# Live Births		Currently breastfeeding	
# Miscarriages		Plans for children in future	
# Abortions		Date of last delivery	
# Tubal Pregnancies			
# Born Dead			
# Now living			

Revised: June 2009

Sexual

Yes	No		Yes	No	
□	□	Pain, discomfort, or bleeding with intercourse	□	□	New sexual partner in the last year
□	□	Recent vaginal infection _____________	□	□	More than one sexual partner in the last year
□	□	Vaginal itching	□	□	Experienced physical abuse (being hit, kicked, slapped)
□	□	Vaginal burning	□	□	Experienced emotional abuse (threatened/made to feel worthless)
□	□	Foul odor	□	□	Forced into sex by family member or partner
□	□	Unusual discharge	□	□	Utilize protection from STDs/HIV_______________
□	□	Treated for an STD in past year _____________	□	□	Treated for pelvic inflammatory infection in past year

How old were you when you first had intercourse? _______
When you were young did someone ever put something in your vagina? □ No □ Yes
Were/Are your sexual partners: □ men □ women □ both □ IV drug users □ partner with multiple partners or at risk for HIV/STD
What types of sex have you had? □ Oral □ Anal □ Vaginal □ None

Contraceptives

Check all of the birth control methods you have used:

□ Abstinence (not having sex)	□ Pill	□ Sterilization	□ Foam, suppository, gel, film
□ Withdrawal	□ Condoms	□ Diaphragm	□ Depo Provera
□ Norplant / Implanon	□ IUD	□ Sponge	□ Birth Control Patch
□ Vaginal ring	□ Natural Family Planning		□ Other_________________

What is the most recent birth control method you have used? _________________________________
Are you using this method now? □Yes □No If no, when did you stop using it? _______________If yes, how long?_______
Have you had problems with any birth control methods? □No □Yes;
Describe____

___________________________________ **Client signature and date**

___________________________________ **Client signature and date updated**

For office use only

Summary of Findings / Recommendations / Referrals: ____

____

____

____

Counseling

Topic	Addressed*	NA	Addressed	NA
Health Promotion				
Tobacco cessation				
Drug/Alcohol Use				
STD/HIV risk reduction				
Overview/Review of Method (s)				
Adolescents Only				
Abstinence				
Resisting Sexual Coercion				
Family Participation				
Report of Abuse or Neglect				

***√ individual boxes when topic Addressed or √ NA when Not Applicable**

Scheduled for exam on______________________ Method given____

Reviewed by: _____________________________________ Date____________________

Updated by: ______________________________________ Date____________________