

**Health Quarters**  
Annual Medical History

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I am adopted. ( )

Father - Living / Deceased    Mother - Living / Deceased (Please circle one)

**PCP – Primary Care Physician:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

	NO	YES	COMMENTS
Are you <b>allergic</b> to any medication?			
Are you taking any <b>medication</b> now?			
<b>FAMILY HISTORY</b>			
Since your last visit has anyone in your family had any heart disease, stroke, high blood pressure, high cholesterol, diabetes, cancer or Osteoporosis?			
<b>PERSONAL HISTORY Since your last visit have you:</b>			
Had any serious illness, surgery, or been hospitalized?			
Had anorexia nervosa or bulimia?			
Had any emotional problems?			
Felt unsafe in a relationship due to physical/sexual threats or violence?			
Been forced to have sex or sexual contact when you didn't want to?			
Had sex without condoms or latex barriers?			
<b>OR a partner</b> shared needles (injecting drugs/ tattooing/piercing)?			
Used alcohol or other drugs before having sex?			
Do you smoke cigarettes? (How many per day? _____)			
Do you use alcohol/pot/crack/cocaine/heroin/tranquilizers/ ecstasy? (Please circle)			
<b>Do you currently:</b>			
Feel you eat a well-balanced diet that includes extra calcium & Vitamin D?			
Exercise regularly?			
Do breast self-exams monthly?			
Have you had the HPV vaccine?			
<b>GYN and SEXUAL HISTORY Since your last visit, have you:</b>			
Had an Abnormal Pap Smear?			
Had a STD (Sexually Transmitted disease)?			
Do you think you might be pregnant now?			
Had sex without a birth control method?			
Had a baby / an abortion / a miscarriage? (Please circle)			
At this time do you have any Vaginal Discharge / Irritation / Itching / Bleeding? (Please circle)			
Do you have sex with Women / Men / Both? (Please circle)			
Do you have Vaginal / Oral / Anal sex? (Please circle)			
Do you have a partner who has multiple partners? No ( ) Yes ( ) Unknown ( )			
Do you have a partner who is at risk for STD/HIV? No ( ) Yes ( ) Unknown ( )			
Do you have a partner who is bisexual? No ( ) Yes ( ) Unknown ( )			
First day of last period:			
When was the last time you had sex? _____	How many partners did you have in the past 12 months? _____		
Do you want to start or change your birth control method? No ( ) Yes ( )	Do you have any problems with your period? No ( ) Yes ( )		
What are you using for Birth Control now? _____			
What do you want to use? _____			

**All information given to Health Quarters is kept confidential**

-----Staff Use Only-----

- History reviewed
- BCMs discussed
- STDs discussed
- HIV/ABC discussed
- ECPs discussed
- Adolescents:
  - Family Involvement encouraged
  - Abstinence encouraged