

**Health Quarters
Initial Medical History**

I am adopted. ()

Today's Date: _____

Father - Living / Deceased

Mother - Living / Deceased (Please circle one)

Primary Care Provider: _____

	NO	YES	COMMENTS
Are you allergic to any medication?			
Are you taking any medication now?			
FAMILY HISTORY			
Cancer (Please specify what type of cancer: _____)			
Diabetes			
Heart Attack before age 55 or other Heart Problems			
High Cholesterol			
High Blood Pressure			
Strokes or Blood Clots			
Birth Defects or Genetic Problems			
Osteoporosis			
PERSONAL HISTORY Have you ever had:			
Heart Problems: Heart Disease, Murmurs, Rheumatic Fever			
Breast Problems			
High Cholesterol			
Blood Problems: Blood Clots, Anemia, Sickle Cell, Thalassemia			
Lung Problems: Tuberculosis, Asthma			
Kidney, Bladder, Urinary Tract Problems			
Liver Problems: Liver Disease, Hepatitis, Mononucleosis, OR Jaundice			
Stomach or Bowel Problems or Gall Bladder Disease			
Cancer			
Hormone Problems or Thyroid Disease			
Diabetes			
Anorexia nervosa or bulimia			
Skin Disorder			
Genetic Condition or Birth Defect			
Frequent or Severe Headaches			
Eye Problems / Blurred Vision (Specify if you wear contacts or glasses)			
Dizziness or Fainting (unusual)			
Epilepsy or Convulsions			
Surgery or Hospitalizations or a Serious Illness			
Blood transfusions, exposure to blood products or solid organ transplant			
Other chronic OR acute medical conditions			
If you were born before 1971, did your mother take DES?			
GYN HISTORY Have you ever had:			
An Abnormal Pap Smear?			
Yeast Infections / Bacterial Vaginosis ? (Please circle)			
Genital Herpes / Genital Warts / Hepatitis B ? (Please circle)			
Chlamydia / Gonorrhea / Syphilis / HIV? (Please circle)			
Problems with Uterus / Fallopian Tubes / Ovaries?			
Pain or Bleeding with intercourse?			
Are there recent changes in your cycle that bother you?			
Do you have any Vaginal Discharge / Irritation / Itching now?			

All information given to Health Quarters is kept confidential

-- Continue on Back Side --

	NO	YES	COMMENTS
LIFESTYLE Have you ever:			
Had emotional problems, depression, or needed counseling?			
Been abused or felt unsafe in a relationship? (Physical/Sexual/Emotional threats or violence)			
Been forced to have sex or sexual contact when you didn't want to?			
Sometimes had sex without condoms or latex barriers?			
Shared needles for injecting drugs (including steroids), tattooing, ear or body piercing - OR - had a partner that did?			
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)			
Have you had the vaccine for measles, mumps, rubella (MMR)?			
Have you had the vaccine for Hepatitis B?			
Have you had the vaccine for HPV?			
Do you eat a well-balanced diet with extra calcium and Vitamin D?			
Do you exercise?			
Do you do breast self-exams monthly?			
SEXUAL HISTORY			
Have you ever had a sexual partner? No () Yes ()	Do you have sex with Women / Men / Both? (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 ()		
Your age at time of first sexual experience?	Do you have Vaginal / Oral / Anal sex? (Please circle)		
When was the last time you had sex?	How many partners did you have in the past 12 months?		
Have you ever been pregnant? No () Yes () Age at first pregnancy: _____ How many Pregnancies? _____ Abortions? _____ Miscarriages? _____ Births? _____ Adoptions? _____ Did you have any problems with pregnancies or births? No () Yes () If yes, explain _____	Do you think you might be pregnant now? No () Yes () Have you had sex without a birth control method since your last period? No () Yes () Do you want to start or change your birth control method? No () Yes () What do you want to use? _____ What do you use for birth control now? _____		
MENSTRUAL HISTORY			
First day of last period:	Are your periods usually: Light / Moderate / Heavy? (Please circle)		
Number of days you usually bleed:	Do you have monthly periods? No () Yes ()		
Do you ever: Miss periods No () Yes () Bleed between periods No () Yes ()	Do you ever: Have pain with periods No () Yes () Take medication for the pain No () Yes ()		

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

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