Reproductive Healthcare of the Big Horns
Medical History Form

Client Name | Age | Date of Birth | Today's Date

LIST all ALLERGIES to food and/or medications?

Who is your regular healthcare provider? _____

Do you have any of these immunizations (shots) completed?

☐ MMR ☐ Tetanus Booster ☐ Hepatitis B series ☐ Hepatitis A
☐ Meningitis ☐ Varicella (Shingles) ☐ HPV (Gardasil)

COMMENTS

	Now	Past	Never	
Please list prescription drugs or over the counter meds including vitamins etc., you take regularly.				
Anemia (iron-poor blood)?				
Any breathing or lung problems?				
Blood clots? Heart disease, stroke or high blood pressure?				
Chronic headaches? Diagnosed migraines?				
Depression or other mental health concerns?				
Diabetes? Other blood sugar problems?				
Liver or gallbladder disease?				
Seizures or diagnosed with epilepsy?				
Thyroid problems or take thyroid medication?				
Have you or your partner(s) used any IV drugs?				
Have you or your partner(s) had a blood transfusion?				
Have you had an operation or been hospitalized?				
Have you ever been forced to have sex?				
Have you been in a relationship with a person who verbally threatens or physically hurts you (hit, slap, kick or otherwise)?				

	Now	Past	Never	
Do you check your breasts for lumps every month? Any concerns today?				
Do you check your testicles for lumps every month? Any concerns today?				
Are you having sex with someone?				
Do you have pain, bleeding, or any other difficulty with sex?				
Have you ever had a sexually transmitted disease?				
Do you have a discharge, rash, sores, bumps, itching, or pain?				
How old were you when you first had sex?				
Do you use condoms regularly?				
Do your partners have other partners besides you?				
How many sexual partners in the past three months?				
How long have you been with your current partner?				
Do you use tobacco products (cigarette, vape or chew)?				
Do you use street drugs (marijuana, cocaine, meth)?				
Do you drink alcohol?				
Any concerns about diet? Do you want to lose/gain weight?				
Do you see your dentist regularly?				
Are you and your partner currently trying to have a child?				

Family History	YES	**NO**	Unknown	
Diabetes?				
Blood clot or other bleeding disorder?				
High blood pressure? Stroke? Heart attack or heart disease?				
Any cancer? What type?				
Birth defects? Genetic disorders?				
Are your parents and siblings generally in good health?				

CONTRACEPTIVE Prevention and Safety

What methods of birth control have you used in the past? D None D Plan B D Depo Provera D Pills

O Diaphragm D Patch D Pulling out D Rhythm D Fertility awareness ☐ Condoms O Sponge

O Vaginal Ring ☐ Spermicidal (foam) D IUD D Sterilization _____

D

What method are you using now?	
What method would you like to use?	

How old were you when your first period started?			
How often do you get your period?			
How many days does your period last?			
Do you have bleeding at other times besides normal period?			
Do you have pain/cramps or other problems with periods?			
What was the first day of your last period?			
When was your last Pap?			
Have you ever had an abnormal Pap?			

List your pregnancies: **Full Term**			
Premature or low birth weight **Abortion /Miscarriage/Still Birth** **Living children** **C-section** **Vaginal**			

The information I have provided on this form is correct and complete to the best of my knowledge.

Client Signature:_____

Witness Signature: _____ Date: _____