Reproductive Healthcare of the Big Horns

Client Name	Age	Date of Birth	Today's Date

I. Do you have any ALLERGIES to food or medication? Please list: _____

II. Medical History: Have you had the following immunizations (shots): **COMMENTS**

Rubella (measles) Tetanus Varicella/Chicken Pox			
Hepatitis B HPV Meningococcal			

Circle if you have or have ever been diagnosed with any of the following:

1. Anemia? Diabetes? High Blood Pressure? High cholesterol?	Yes	No	
2. Blood clots in legs, lungs, head? Heart Disease, stroke?	Yes	No	
3. Thyroid problems, PKU?	Yes	No	
4. Urinary tract (bladder) or kidney infection?	Yes	No	
5. Headaches, migraines w/vision changes, seizures or epilepsy?	Yes	No	
6. Asthma? Tuberculosis or other lung disease?	Yes	No	
7. Breast problems? Cancer? Where and when?	Yes	No	
8. Hepatitis, liver, gallbladder disease?	Yes	No	
9. Depression or other mental health concerns?	Yes	No	
10. **Have you had an operation or been hospitalized? When? Why?**	Yes	No	
11. Are you taking any prescriptions or over the counter medications, including folic acid, calcium, vitamins or supplements? Please list.	Yes	No	
12. Are there any other health issues we need to know about? Please include learning disabilities, physical or mental issues.	Yes	No	

III. FAMILY HEALTH HISTORY **COMMENTS**

Does anyone in your immediate family (mother, father, sister, brother, child) have a history of: (If yes, list who)				
****I am adopted** (Please enter any information you have on your biological family: otherwise proceed to LIFESTYLE HISTORY)				
1. Diabetes, sugar in blood or urine?	Yes	No	Unsure	
2. High blood pressure, stroke, heart attack, heart disease?	Yes	No	Unsure	
3. High blood cholesterol? Cancer? What type?	Yes	No	Unsure	
4. Birth defects? Genetic disorders? What are they?	Yes	No	Unsure	
5. Clotting disorders?	Yes	No	Unsure	
6. Did your mother use DES while pregnant with you?	Yes	No	Unsure	

IV. LIFESTYLE HISTORY **COMMENTS**

1. Do you visit a dentist at least one a year?	Yes	No	
2. Do you drink alcohol? How much? How often? Last time?	Yes	No	
3. Do you use tobacco products (cigarettes or chew)? How much per day? _____ How long have you been smoking/using chew? Months? Years?	Yes	No	
4. Do you use street drugs (marijuana, cocaine, crack, meth)? What kind? How often? Last time?	Yes	No	
5. Are you concerned about your diet or eating habits? Anorexia/Bulimia? Other?	Yes	No	
6. Are you now or ever been in a relationship with a person who threatens or physically hurts you (hit, slap, kick or otherwise)?	Yes	No	

7. Has anyone ever forced you to have sexual activities that made you uncomfortable?	Yes	No	

Name: _____

V. CONTRACEPTIVE HISTORY	COMMENTS
1. What methods of birth control have you used in the past? Pill IUD Patch Abstinence Natural Sponge Sterilization Diaphragm Condoms Depo Provera shot Spermicidal (foam) EC/Plan B Pulling out Ring None Other	
2. What method are you using now?	
3. Are you having any problems with your current method?	
4. What method would you like to use?	

VI. MENSTRUAL/GYNECOLOGICAL HISTORY			COMMENTS
1. How old were you when your first period started?			
2. How often do you get your period?			
3. How many days does your period last?			
4. What was the first day of your last period?			
5. Do you have pain/cramps or other problems with your period?	Yes	No	
6. Do you bleed between periods?	Yes	No	

VII. SEXUAL HISTORY (Including STD/HIV risk factors)			COMMENTS
1. When was your last Pap smear?			
2. Have you ever had an abnormal Pap?	Yes	No	
3. Do you have sex with men, women or both?			
4. How long have you been with your current partner?			
5. How many sexual partners in the past six months?			
6. Do your partner (s) have other sexual partners besides you? If so, are they: women men	Yes	No	
7. Do you have pain or bleeding or any other difficulty with sex?	Yes	No	
8. **Have you ever been treated for a sexually transmitted infection (Chlamydia, Gonorrhea, warts, HPV, HIV)**	Yes	No	
9. **Do you have any discharge, rashes, sores, bumps, itching? (Circle)**	Yes	No	
10. Have you/your partner(s) ever used intravenous (IV) drugs?	Yes	No	
11. Have you/your partner(s) had a blood transfusion?	Yes	No	
12. Do you want STD or HIV testing?	Yes	No	

VIII. PREGNANCY HISTORY	Yes	No	
1. Have you ever been pregnant?	Yes	No	
2. List the number and dates of: Full term _____ Premature or low birth weight _____ Abortion/Miscarriage/Still birth _____ Living children			Complications?
3**. Do you desire a pregnancy in the future? If yes, when?**	Yes	No	
4**. Do you have a primary care doctor or clinician**	Yes	No	Name of doctor or clinician:

Do you have any other health concerns that you want to discuss with us today? Please list or tell the nurse.

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

_____(client's signature)

Signature of clinic staff: _____Date _____(Updated 6.2012)