REPRODUCTIVE HEALTHCARE OF THE BIG HORNS

Clients Name	Date of Birth	Today's Date

I. **HEALTH HISTORY**	Yes	No	Don't Know	Comments
Does anyone in your immediate family (mother, father, sister, brother) have a history of: (If yes, list who)				
I am adopted (Please enter any information you have on your biological family: otherwise proceed to MEDICAL HISTORY				
1. Diabetes, sugar in blood or urine?				
2. High blood pressure?				
3. High blood cholesterol?				
4. Stroke? Clotting disorders?				
5. Heart attack, heart disease?				
6. Cancer? What type?				
7. Birth defects? Genetic disorders? What?				

II. **MEDICAL HISTORY**: Have you had the following immunizations (shots):

1. Hepatitis B				
2. Tetanus				

Do **YOU** have or have you ever had any of the following:	Yes	No	Comments
3. Do you have allergies to food, medications, latex? Please list:			
4. Diabetes?			
5. Hepatitis, liver or gallbladder disease?			
6. Bladder or kidney infection/disease or pain or bleeding with urination?			
7. Asthma, TB or other lung problems?			
8. High blood pressure?			
9. High blood lipids: cholesterol & or triglycerides?			
10. Stroke or blood clots in the legs, lungs or head?			
11. Frequent indigestion, constipation, nausea or rectal problems?			
12. Heart disease, chest pain or shortness of breath?			
13. Conditions affecting penis, testicles or prostate?			
14. Problems with erection or ejaculation?			
15. Cancer? Where and when?			
16. Thyroid or other metabolic problems?			
17. Depression or any psychological problems?			
18. Seizures or Epilepsy?			
19. Have you had an operation or been hospitalized? When and why?			
20. Are you currently taking any prescription medications or over the counter (OTC) medications including vitamins, minerals, herbal or dietary supplements? Please list:			

Client Name: _____

	Yes	No	Comments
21. Are you circumcised?			

III LIFESTYLE HISTORY	Yes	No	Comments
1. Do you check your testicle for lumps?			
2. Do you drink alcohol? How much? How often?			
3. Do you use tobacco products (cigarettes or chew)? How much per day? How long? Months: Years:			
4. Do you use street drugs (marijuana, cocaine, crack,meth)? What kind? How often?			
5. Do you have any concerns that you may have an eating disorder?			
6. Are you now or have you ever been in a relationship with a person who threatens or physically (hit, slap, kick or otherwise) hurts you?			
7. Has anyone ever forced you to have sexual activities that made you uncomfortable / forced you to have sex?			

IV. CONTRACEPTIVE HISTORY	Yes	No	Comments
1. Are you and/or your partner currently using any method of birth control? If yes, what?			
2. Are you having any problems with this method? Would you like information about another method?			

VI SEXUAL REPRODUCTIVE HISTORY

(Including STD/HIV Risk Factors)	Yes	No	Comments
1. Are you having sex with someone? If yes, male female both			
2. How many partners have you had in the past 60 days/lifetime?			
3. Does your partner (s) have sex with: women and/or men			
4. How old were you when you first had sex? Age:			
5. Have you ever been treated for a sexually transmitted disease (STD) or sexually transmitted infection (STI)?			
6. Do you have any symptoms of an STD / STI now (rash, sores, bumps, discharge or burning with urination)?			
7. Have you/your partner (s) ever used intravenous (IV) drugs?			
8. Have you/your partner (s) had a blood transfusion?			
9. Are you concerned that you may have been exposed to the AIDS virus?			
10. Do you have any biological children?			
11. Do you plan to have children in the future?			

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

_____ (client's signature)

Name of Clinic Staff member that reviewed this form: _____ Form 8.2010