# FEMALE - MEDICAL HEALTH HISTORY

This medical record is confidential and will not be released to anyone except as may be required by law.

Oneida County
Reproductive Health Clinic
100 W KeenanSt
Rhinelander, WI 54501
715-369-6116

Client Name:_________________
Client No._____________
Date: ______/______/___

Name:_____________________________________________________ Date of Birth _____/_____/________ Age ________
(Last) (First) (MI) mm / dd / yyyy
Please call me (preferred name) ___________________________________ Preferred gender: He___ She___ Other: ____ Reason for visit___
Have you or your partner recently traveled to a region with known Zika or Ebola transmission? ___Yes ___No If yes, where: Please _________________
check if you are allergic to:
❑ Penicillin ❑ Iodine ❑ Zithromax ❑ Doxycycline ❑ Sulfa ❑ Metal ❑ Rocephin ❑ Tetracycline ❑ Latex
❑ Amoxicillin ❑ Local anesthetic ❑ No allergies ❑ Other(s): _______________________________________
List medications, vitamins, over the counter drugs, and/or herbs you take:________________________________________________
Have you recently taken antibiotics ____ Yes _____No If yes, when?: ____________ for what?:____________what kind?:_________________

## MENSTRUAL HISTORY

Day last period began: __________________________ Was it Normal? ____Yes ____No
Do you have bad cramps? ____ Yes ____ No
Do you bleed heavy? ____ Yes ____ No Age when periods started: ___________
Have you had sex since your period? ____Yes ____ No

## SEXUAL HISTORY

Have you ever had sex? ____Yes ____ No
Have you or your partner had more than one sexual partner in your lifetime? ____Yes ____ No
Have you had a new partner or more than one partner in the last 90 days? ____Yes ____ No ___Don't know
Has your partner(s) had a new sex partner or more than one partner in the last 90 days? ____Yes ____ No ___Don't know
Have you ever engaged in a sexual activity where you felt you couldn't say no? ____Yes ____ No
Check if you have: ____vaginal sex ____ oral sex ____ anal sex ____ sex with men ____ sex with women ____ sex with both
Check if you have ever had: ____ Chlamydia _____ Gonorrhea _____HPV/warts ____ Herpes _____Syphilis
Have you or your partner(s) used IV drugs? ___Yes ___ No ____ Don't know
Have you had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days? ___Yes ___ No
Has your partner had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days? ____Yes ____ No ___Don't know

## PREGNANCY

(If never been pregnant – go to next section). ➔➔➔➔
How many times have you been pregnant? __________
Dates when your pregnancy(s) ended ______________
Are you breastfeeding? ____ Yes ____ No

## REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? ____Yes ____ No
How many children do you hope to have? _____________
How long do you plan to wait until you (next) become pregnant? ______________
What do you plan to do until you are ready to get pregnant?
________________________________________________________
What can I do today to help you achieve your plan?
________________________________________________________

## CONTRACEPTIVE HISTORY

Do you ALWAYS use condoms? ____ Yes ____ No
Are you using birth control now? ____Yes ____ No If yes, what kind ______________________________
Do you want birth control today? ____Yes ____ No If yes, what kind ______________________________
What kind of birth control have you used in the past? ________________________________________________
Any problems with those methods?____________________________________________________________
Does your sexual partner(s) agree with your decision to prevent pregnancy and use birth control at this time? ____Yes ____ No Has anyone ever done anything to your birth control – i.e. thrown away your pills, patches, rings or taken their condom off before or during sex? ____Yes No

## SOCIAL HISTORY

Do you smoke cigarettes? ____ Yes ____ No If yes, _____# per day Do you want to quit? ____Yes ____ No
Do you drink alcohol? ____Yes ____No Do you use street drugs? ____Yes ____ No
Does alcohol/drugs cause problems in your life and/or are others concerned? ____Yes ____ No
Do you feel threatened or afraid of someone in your life? _____ Yes ____ No
Check if you have any concerns about: ____ Date rape _____ Forced/unwanted sex _____ Physical abuse _____Weight
Have you ever received medical care/medications for your mental health? ____Yes ____ No

## PAST MEDICAL HISTORY

Have you ever been in the hospital? ____Yes ____ No If yes, why ________________________________________
Do you have a doctor? ____Yes ____ No If yes, Doctor's name: ___________________________________________
List any medical problems: ____________________________________________________________________________
Date of your last pap smear? ___________________________________ What Clinic?___________________________

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CLINIC NAME
ADDRESS/PHONE/FAX
CONTACT INFORMATION

Client Name:___________________
Client No._____________________
Date: ______/______/________

Do you now have or have you ever had:

Yes No
___ ___ Abnormal pap test
___ ___ Anemia
___ ___ Asthma
___ ___ Breast surgery or disease
___ ___ Cancer
___ ___ Diabetes
___ ___ Diagnosis w/HIV/AIDS
___ ___ Blood disorders/Problems with your blood

Yes No
___ ___ Endometriosis or ovarian cysts
___ ___ Gall Bladder disease
___ ___ Genetic condition
___ ___ Heart Disease/High blood pressure
___ ___ High Cholesterol
___ ___ Mono or Hepatitis
___ ___ Mitral Value Prolapse (MVP)
___ ___ DES Exposure

Yes No
___ ___ Pelvic Infection/PID
___ ___ Sickle cell anemia, trait of Thalassemi
___ ___ Stroke
___ ___ Thrombophlebitis/blood clot(s)
___ ___ Tuberculosis
___ ___ Uterine growth/fibroid
___ ___ Seizure disorder/epilepsy
___ ___ Bariatric surgery

## FAMILY HISTORY

If you are adopted and do not know your family's medical history go to next section.
Does your mother, father, brother, or sister have any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Stroke | ___ Yes ___ No | Diabetes | ___ Yes ___ No | Breast Cancer | ___ Yes ___ No |
| Heart Attack | ___ Yes ___ No | High Cholesterol | ___ Yes ___ No | Ovarian Cancer | ___ Yes ___ No |
| Blood Clot | ___ Yes ___ No | High Blood Pressure | ___ Yes ___ No | Prostate Cancer | ___ Yes ___ No |

## REVIEW OF SYSTEMS

A. General
Yes No
___ ___ Recent weight gain or loss (+25 lbs)
___ ___ Reactions to drugs or foods

B. Cardiovascular
Yes No
___ ___ Chest Pain
___ ___ Palpitations
___ ___ Varicose Veins

C. Genitourinary
Yes No
___ ___ Blood in urine
___ ___ Pain or burning with urination
___ ___ Frequent urination
___ ___ Vaginal discharge, itching, irritation, odor
___ ___ Bumps, sores, rash in vaginal area
___ ___ Have you urinated in past hour?
___ ___ Do you have pain with sex?

D. Skin
Yes No
___ ___ Acne
___ ___ Rash/itching
___ ___ Night sweats/hot flashes/fever/chills
___ ___ Other skin problems

E. Breasts
Yes No
___ ___ Breast lump
___ ___ Breast pain
___ ___ Nipple discharge

F. Eye, Ears, Nose, Throat
Yes No
___ ___ Hearing problems
___ ___ Frequent nose bleeds
___ ___ Frequent sore throat
___ ___ Thyroid problems
___ ___ Blurred vision/double vision

G. Respiratory
Yes No
___ ___ Chronic cough
___ ___ Shortness of breath/ breathing problems

I. Musculoskeletal
Yes No
___ ___ Muscle or bone pain
___ ___ Back pain

H. Neuro/Psych
Yes No
___ ___ Convulsions/Seizures
___ ___ Difficulty with memory or speech
___ ___ Emotional problems
___ ___ Sadness
___ ___ Nervousness
___ ___ Numbness/tingling
___ ___ Headaches

J. Gastrointestinal
Yes No
___ ___ Abdominal pain
___ ___ Nausea/vomiting
___ ___ Changes in bowel habits
___ ___ Changes in appetite
___ ___ Constipation/diarrhea
___ ___ Rectal pain or bleeding

K. Immunizations (check all you've had)
❑ Tetanus ❑ Hepatitis A ❑ Pertussis ❑ Gardasil/HPV
❑ Rubella ❑ Hepatitis B ❑ Meningococcal
❑ Measles ❑ Mumps ❑ Chicken Pox

## DIET & EXERCISE

# of servings of the following/per day: ____Dairy ___ Protein ____ Vegetables ____ Fruits ___ Grains
How many meals do you eat a day?__________ How much coffee, tea and soda per day?________________
What do you do for physical activity?________________________ How many hours of sleep do you get?___________

To the best of my knowledge the above information is complete and correct.

Patient Signature ______________________________________________ Date _______/_______/______
Staff notes:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Face-to-Face time:__________ Ed & Counseling Time:_________________
Staff Signature: ______________________________________________ Date _______/_______/ ______

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