# FEMALE - MEDICAL HEALTH HISTORY

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

**Polk County Reproductive Health**
**100 Polk County Plaza, Ste. 180**
**Balsam Lake, WI 54810**
**715-485-8575**

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?_____



**Issued Date: 12/31/10 | Revised Date: 9/21/2016**

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Client Name:_____
Client No._____
Date: _____/_____/_____

Do you now have or have you ever had:

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Abnormal pap test | ___ | ___ | Endometriosis or ovarian cysts | ___ | ___ | Pelvic Infection/PID |
| ___ | ___ | Anemia | ___ | ___ | Gall Bladder disease | ___ | ___ | Sickle cell anemia, trait of Thalassemi |
| ___ | ___ | Asthma | ___ | ___ | Genetic condition | ___ | ___ | Stroke |
| ___ | ___ | Breast surgery or disease | ___ | ___ | Heart Disease/High blood pressure | ___ | ___ | Thrombophlebitis/blood clot(s) |
| ___ | ___ | Cancer | ___ | ___ | High Cholesterol | ___ | ___ | Tuberculosis |
| ___ | ___ | Diabetes | ___ | ___ | Mono or Hepatitis | ___ | ___ | Uterine growth/fibroid |
| ___ | ___ | Diagnosis w/HIV/AIDS | ___ | ___ | Mitral Value Prolapse (MVP) | ___ | ___ | Seizure disorder/epilepsy |
| ___ | ___ | Blood disorders/Problems with your blood | ___ | ___ | DES Exposure | ___ | ___ | 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 |

H. Neuro/Psych

| Yes | No | |
|---|---|---|
| ___ | ___ | Convulsions/Seizures |
| ___ | ___ | Difficulty with memory or speech |
| ___ | ___ | Emotional problems |
| ___ | ___ | Sadness |
| ___ | ___ | Nervousness |
| ___ | ___ | Numbness/tingling |
| ___ | ___ | Headaches |

I. Musculoskeletal

| Yes | No | |
|---|---|---|
| ___ | ___ | Muscle or bone pain |
| ___ | ___ | Back pain |

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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