FEMINIST WOMEN'S HEALTH CENTER
MEDICAL HISTORY

Date ____/_____/______

Legal Name ____ Preferred Pronoun (he/she/ze) ___________
Preferred Name______________________________________ DOB _____/____/_____ Age ________
Address ____ Apt # ________ Phone (h) (____)_____-________
City _________________________ Within City Limits: Yes ( ) No ( ) (w) (____)_____-________
County _______________________ State __________ Zip _________ (c) (____)_____-________
At what phone # may we contact you?_______________________ May we leave a message: Yes ( ) No ( )
Emergency contact: Name ____
Address ____ Apt # ________ Phone (h) (____)____-_________
City ______________________________ State __________Zip _________ (w) (____)____-_________
Years of Education: _____________Language you speak: English, Spanish, French, Other____________________
Can you read/understand English to fill out this form: Yes ( ) No ( )
If not English speaking, Interpreter's name ____
Pharmacy # ____ Religion ______________________________
DRUG ALLERGIES: __________________________________ FOOD ALLERGIES: ______________________
CURRENT MEDICATIONS: ____

Please circle Y for yes or N for no, or fill in the space for the following questions:

Contraceptive History (Birth Control):

1. Y N Do you need/want birth control method/information. If you answered NO, skip to # 7.
2. Y N Is this a non-abortion visit and you are having intercourse/ risk for pregnancy
3. Current method of birth control used: _________________________________
4. How long using this method; ____________ Problems: Y N
   Describe: ____
5. **What method do you want to use now?** ______________________________
6. Methods used in past: (circle): Pills / Patch / Ring / Shot / Norplant / IUD / condoms / cervical cap / diaphragm / foam / gel / sponge / abstinence / withdrawal / sterilization / tubes tied / vasectomy / rhythm / Natural Family Planning / Emergency Contraception / other _______________

Comments - Staff Only

Sexual History/ Information: this information helps us with your care:

7. Age of first sexual experience ____Currently in sexual relationship: Y N
   Partner(s): men / women / both now ( ) always ( )
   Do you have more than one partner? Y N
   # partners in last year: _____Do you practice safe sex Y N
   Need information on safe sex Y N
   Recent change in partner Y N
   Do you have (circle): vaginal / oral / anal sex
   Partners History (circle all that apply):
   Has other partners, has same-sex partners,
   is a hemophiliac, is HIV+/ has AIDS
   uses recreational drugs

Social History:

Circle Y for yes or N for no to the following indicating your recent experience:

8. Y N Death of family member/friend
9. Y N Emotional/relationship problems
10. Y N Job loss/financial problems
11. Y N Problems in living arrangements/schools
12. Y N Legal problems/arrests/divorce
13. Y N Parental problems
14. Y N Has anyone forced you to have sex
15. Y N Are you afraid of your partner/family member
16. Y N Do you smoke? How many cigarettes/day ___________
17. Y N Do you drink? How much alcohol do you drink per week __________________
18. Y N Do alcohol/drugs cause problems in your life?
19. Y N Have you ever abused alcohol? Yes ( ) No ( ) Drugs? Yes ( ) No ( )
20. Y N Emotional/ mental illness? Anti-Depressive, anxiety or psychotic medications
21. Y N Feel you are in an abusive relationship
22. Y N As a child did anyone touch your private body parts or ask you to touch theirs
23. Y N Do you have any piercings in your mouth

Comments - Staff Only

24. Y N Do you feel you need to speak to a counselor of any kind
25. Y N Do you use recreational drugs
    What kind? __________________________ Last date of use ____________
26. Who helps and supports you with your problems _________________________
27. Who do you live with __________________

OB History:

Complete below:

28. Total No. Pregnancies including current: _______ Living children: _______
    Live births: ______ Miscarriages: ______ Abortions: _______
    Ectopic/tubal: ____ Other: ______________________________
    # of C-sections: ________ Last pregnancy when: __________
    Problems with pregnancies: (high blood pressure, seizures, toxemia, gestational diabetes, birth defects) other: ___________________
29. **Are you Rh neg: Y N Have you received Rhogam: Y N**
30. Y N Trouble getting pregnant/staying pregnant
31. Y N Used fertility treatments/medications
32. Y N Had artificial insemination (s)

Personal Medical History:

Circle Y for yes or N for no to the following and circle items that apply: (Current & Past)

33. Y N Eye/vision problems, glasses/contacts
34. Y N Deaf/Mute. Do you know sign language Yes ( ) No ( )
35. Y N Heart problems/palpitations/murmurs/surgery/MVP (Mitral Valve Prolapse)
36. Y N High Blood Pressure
37. Y N Strokes/Blood Clots in head, heart, brain/Head injury
38. Y N Varicose veins
39. Y N High cholesterol/ blood fats
40. Y N Diabetes/High Sugar: (insulin/diet /oral/) Only with pregnancy
41. Y N Bladder/Kidney problems/infections
42. Y N Headaches/migraine, stress related or other
43. Y N Seizures/epilepsy: Date of last seizure_____________
44. Y N Thyroid conditions/ medications
45. Y N Liver disease/Hepatitis
46. Y N Stomach problems/gastritis/ ulcers/reflux disease
47. Y N Bowel problems/Colitis/Irritable bowel/Crohns
48. Y N Lung Problems/Disease/Asthma=(circle one) Childhood, Seasonal; Chronic
49. Y N Anemia/Low Iron/Sickle Cell/Thalassemias/Blood diseases/Lupus
50. Y N Gallbladder disease/Surgery
51. Y N Cancer
52. Y N Numbness in legs or arms
53. Y N Are you currently under care for a problem/illness by a health care professional? Explain ____
54. Y N Have you ever been hospitalized (except childbirth):
    Explain ____
    ____
55. Y N Received blood products before 1978
56. Y N Do you faint with needles/finger sticks/pap smears
57. Y N Ever react to ANY DRUG/MEDICATION/FOOD: including (circle):
    barbiturates, anesthesia, shellfish, eggs, soy, Iodine, metals, latex ____________
58. Y N Have you ever been put to sleep for any surgery? Did you have any problems-Y N
59. Y N Immunizations up to date: Last tetanus: ________
    Rubella vaccination: Y N Hepatitis B: Y N
60. Y N Do you use herbs/vitamins/complimentary therapies

Comments - Staff Only

GYN History:

Circle Y for yes or N for no to the following:

61. Y N Have you <u>ever</u> had a pelvic exam/ Pap smear? Date of last exam ______________
62. Y N Breast disease or surgery
63. Y N Breast/nipple discharge/leaking
64. Y N Are you breast feeding/nursing
65. Y N Mammogram
66. Y N Vaginal infections/itching /burning
67. Y N Vaginal pain/bumps/swelling/sores
68. Y N Sexually transmitted infections (circle all that apply):
    Herpes, Warts, Chlamydia, Gonorrhea, Trichomonas, Syphilis,
    HIV, Hepatitis B, Group B Streptococcal Infection
69. Y N Pelvic inflammatory disease (PID) Date______
    Treatment: ______________________________
70. Y N Endometriosis/Uterine fibroids
71. Y N Cysts on ovaries
72. Y N Abnormal Pap (date) ____________
    Treatment: Repeat pap (date) ______________
    Colpo/Cryo/LEEP/Laser
73. Y N Genital circumcision
74. Y N Bleeding and/or pain with sex
75. Y N Did your mother take medications to prevent miscarriage
    when pregnant with you? DES ( ) other ( )

Menstrual History:

76. Age period began ____________
    Are your cycles/periods regular? Yes ( ) No ( ) Sometimes ( )
    # days in each cycle: ________ # days you bleed: _______
    Use pads / tampons / other _______ # used on heaviest day(s) _______
77. Y N Cramps/pain/bloating/depression
78. Y N Do you use medications/herbs/other ___________________ for relief
79. Y N Bleed between periods
80. Y N Menopausal/Peri menopausal
81. First day of last period _____/______/_____ Normal ( ) Abnormal ( )

Family History: **Adopted: Y N**

Fill in below: mom, dad, siblings, grandparents, aunts, and uncles

82. Y N Diabetes ____
83. Y N Heart attack before age 50 ____________________________________
84. Y N High Blood Pressure ____
85. Y N Cancer (breast, ovarian, uterus) _______________________________
86. Y N Osteoporosis ____
87. Y N High cholesterol ____
88. Y N Alcoholism/addictions/mental illness ___________________________
89. Y N Problems with General Anesthesia______________________________
90. Y N Birth defects/genetic illness ___________________________________

- I affirm that all of the medical information stated above is true and that I have not had anything to eat, drink or gum since__________

And that I do not have any valuables with me at this time. Client Signature____________________________________ Date: ___________

Client signature ____ Date: _________________ Updated: _______________________

Counselor signature____ Date: _________________ Updated: _______________________

RN Pre-op Signature____ Date: ___________________ Updated: ______________________

MD Review __________________________________ Date:___________ Time:_________ Updated: ______________ Time: ___________

APN/CRNA Review___________________________ Date:___________Time:_________ Updated: ______________ Time: ___________

This information is confidential and will not be released without your written permission.