| Name:  |
| --- |
| Today’s date:  |
| Birth Date: Age:  |
| Primary Care Provider:  |
| List any prescriptions or over the counter medicines you are taking now  |
| List any medicines, foods, latex, etc. that you are allergic to and the reaction you have:  |

|  |
| --- |
| **Your Medical History**  |
| **Yes** | **No** | **Do you have now or have you had any of the following?** | **Staff Comments** |
| **[ ]**  | **[ ]**  | Have you been to the ER or hospitalized in the last year? |  |
| **[ ]**  | **[ ]**  | Surgery - List type and date:    |  |
| **[ ]**  | **[ ]**  | Cancer: What type? When?  |  |
| **Ears/Nose/Mouth/Throat/Eyes** |
| **[ ]**  | **[ ]**  | Eye problems (except glasses or contacts) |  |
| **[ ]**  | **[ ]**  | Hearing problems |  |
| **Cardiovascular** |
| **[ ]**  | **[ ]**  | Heart disease, murmur, high blood pressure |  |
| **[ ]**  | **[ ]**  | High cholesterol/triglycerides |  |
| **[ ]**  | **[ ]**  | Blood clots in arms/legs/chest |  |
| **[ ]**  | **[ ]**  | Heart attack or stroke |  |
| **Respiratory/Upper Body** |
| **[ ]**  | **[ ]**  | Breathing problems or Asthma |  |
| **[ ]**  | **[ ]**  | Breast lumps or nipple discharge |  |
| **[ ]**  | **[ ]**  | Mammogram and/or breast ultrasound Date:  |  |
| **[ ]**  | **[ ]**  | Tuberculosis or exposure to tuberculosis |  |
| **Gastrointestinal** |
| **[ ]**  | **[ ]**  | Stomach or bowel problems |  |
| **[ ]**  | **[ ]**  | Gall bladder disease |  |
| **[ ]**  | **[ ]**  | Liver disease (hepatitis, mono, jaundice, cirrhosis) |  |
| **Genitourinary** |
| **[ ]**  | **[ ]**  | Kidney or bladder problems |  |
| **[ ]**  | **[ ]**  | Burning urination and/or blood in urine |  |
| **Musculoskeletal** |
| **[ ]**  | **[ ]**  | Arthritis or osteoporosis |  |
| **[ ]**  | **[ ]**  | Gout |  |
| **Skin** |
| **[ ]**  | **[ ]**  | Acne or other skin problems – Please specify:  |  |
|  |  | **Endocrine** |  |
| **[ ]**  | **[ ]**  | Thyroid problems |  |
| **[ ]**  | **[ ]**  | Diabetes |  |
| **Neurological** |
| **[ ]**  | **[ ]**  | Migraines or frequent headaches |  |
| **[ ]**  | **[ ]**  | Epilepsy or convulsions |  |
| **Hematological/Lymphatic** |
| **[ ]**  | **[ ]**  | Blood problems (Sickle cell anemia, hemophilia, low iron) |  |
| **[ ]**  | **[ ]**  | Have you or your partner(s) ever had a blood transfusion, tissue/organ transplant or artificial insemination? |  |

| **Your Medical History (Continued)** |
| --- |
| **Yes** | **No** | **Do you have now or have you had any of the following?** | **Staff Comments** |
| **Psychological** |
| **[ ]**  | **[ ]**  | Depression or emotional problems |  |

| **Your Family History****[ ]** Please check here if you don’t know your family history. |
| --- |
| **Yes** | **No** | **Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.** | **Staff Comments** |
| **[ ]**  | **[ ]**  | Blood clots in arms/legs/chest  |  |
| **[ ]**  | **[ ]**  | Bleeding problems ­­­­­­­­­­  |  |
| **[ ]**  | **[ ]**  | High blood pressure  |  |
| **[ ]**  | **[ ]**  | High cholesterol/triglycerides  |  |
| **[ ]**  | **[ ]**  | Breast/ovarian/uterine/colon cancer  |  |
| **[ ]**  | **[ ]**  | Heart attack  |  |
| **[ ]**  | **[ ]**  | Stroke  |  |
| **[ ]**  | **[ ]**  | Diabetes  |  |
| **[ ]**  | **[ ]**  | Birth defects/genetic disorders  |  |
| **[ ]**  | **[ ]**  | Alcohol/drug abuse  |  |
| **[ ]**  | **[ ]**  | Mental health disorders  |  |
| **[ ]**  | **[ ]**  | Physical or sexual abuse  |  |

| **Your Personal History** |
| --- |
| **Yes** | **No** |  | **Staff Comments** |
| **[ ]**  | **[ ]**  | Have you had the HPV vaccine series |  |
| **[ ]**  | **[ ]**  | Do you smoke tobacco? Everyday Somedays Former SmokerNever smoked |  |
| **[ ]**  | **[ ]**  | Do you drink alcohol? How many drinks per day? \_\_\_\_\_ per week? \_\_\_\_\_\_\_\_ |  |
| **[ ]**  | **[ ]**  | Do you use marijuana or marijuana products? How often? |  |
| **[ ]**  | **[ ]**  | In the past year, have you used an illegal drug or a prescription drug for non-medical reasons? |  |
| **[ ]**  | **[ ]**  | Do you vape, chew, or use any form of a nicotine delivery system other than smoking? |  |
| **[ ]**  | **[ ]**  | Do you exercise? How often? |  |
| **[ ]**  | **[ ]**  | Do you use caffeine? How often? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **[ ]**  | **[ ]**  | How often are you around people who regularly use tobacco, alcohol, or drugs? |  |
| **[ ]**  | **[ ]**  | Have you ever been hit, slapped, kicked, shaken or hurt by anyone? |  |
| **[ ]**  | **[ ]**  | Have you ever been forced to have sex? |  |
| **[ ]**  | **[ ]**  | Is there anyone who makes you feel unsafe now? |  |
| **[ ]**  | **[ ]**  | When was the last time you were out of the country? |  |
| **[ ]**  | **[ ]**  | Have you had tetanus, diptheria, pertussis (Td/Tdap) vaccine? When? |  |

|  |
| --- |
| **Your Sexual History**  |
| **Yes** | **No** | **Have you ever had any of the following sexually transmitted infections:** | **Staff Comments** |
| **[ ]**  | **[ ]**  | Chlamydia |  |
| **[ ]**  | **[ ]**  | Gonorrhea |  |
| **[ ]**  | **[ ]**  | Genital warts/Human Papillomavirus (HPV) |  |
| **[ ]**  | **[ ]**  | Syphilis |  |
| **[ ]**  | **[ ]**  | Herpes |  |
| **[ ]**  | **[ ]**  | Trichomoniasis |  |
| **[ ]**  | **[ ]**  | Non-gonococcal urethritis (NGU) |  |
| **[ ]**  | **[ ]**  | Have you or your sexual partner(s) ever used needles for drugs (to shoot drugs)? |  |
| **[ ]**  | **[ ]**  | Have you or your sexual partner(s) ever exchanged sex for drugs or money? |  |
| **[ ]**  | **[ ]**  | Do you use condoms?[ ]  Never [ ]  Sometimes [ ]  Always |  |
| **[ ]**  | **[ ]**  | Have you had HIV testing? When?  |  |
| **[ ]**  | **[ ]**  | Was the HIV test positive (HIV infection found)? |  |
| **[ ]**  | **[ ]**  | Have you had a new partner in the past 2 months? |  |
| **[ ]**  | **[ ]**  | Does your sex partner have other partners? |  |
| 1. How many sexual partners have you had in the past 2 months? 2. How many sexual partners have you had in the past year? 3. Are your sex partners: [ ]  male [ ]  female [ ]  both [ ]  transman [ ]  transwoman [ ]  intersex [ ]  other4. Do you have: [ ]  Vaginal sex [ ]  Oral sex [ ]  Anal sex 5. When was the last time you had sex? 6. Have any of your male partners had sex with other men? [ ]  Yes [ ]  No [ ]  Not Sure [ ]  N/A7. Are any of your sex partners living with HIV? [ ]  Yes [ ]  No |

| **(Male/Assigned male at birth/MTF)** |
| --- |
| **Your Urological History** |
| **Yes** | **No** |  |
| **[ ]**  | **[ ]**  | Do you have abnormal discharge from the penis now? |
| **[ ]**  | **[ ]**  | Do you have now or in the past a lesion, sore, or lump on your penis? Describe: When?  |
| **[ ]**  | **[ ]**  | Do you have now or had in the past a lesion, sore, or lump on your scrotum or testicles?Describe: When?  |
| **[ ]**  | **[ ]**  | Have you ever had pain during sex? When?  |
| **[ ]**  | **[ ]**  | Have you had gender affirming surgery? If so, describe:  |
| **Your Reproductive History** |
| **[ ]**  | **[ ]**  | Do you have any children? How many?  |
| **[ ]**  | **[ ]**  | Do you plan to have children? When? **[ ]**  Now[ ]  1-2 Years [ ]  3-5 Years [ ]  5+ Years [ ]  Unsure |
| **[ ]**  | **[ ]**  | Are you using birth control?Please check the birth control method(s) you use: **[ ]** Condoms **[ ]** Vasectomy **[ ]** Rely on partner’s method. What method does your partner use?  |

| **(Female/Assigned female at birth/FTM)** |
| --- |
| **Yes** | **No** |  |
| **[ ]**  | **[ ]**  | Do you plan to have children? When? **[ ]**  Now[ ]  1-2 Years [ ]  3-5 Years [ ]  5+ Years [ ]  Unsure |
| **Your Menstrual History** |
| Date of the first day of your last menstrual period:  |
| **Yes** | **No** |  |
| **[ ]**  | **[ ]**  | Was your last menstrual period normal?If not, explain:  |
| **[ ]**  | **[ ]**  | Do you have a period every month? Is the flow: [ ]  light [ ]  medium [ ]  heavy |
| **[ ]**  | **[ ]**  | Do you bleed between periods? |
| **[ ]**  | **[ ]**  | Do you have cramps with your periods? |
| **[ ]**  | **[ ]**  | Do you take medication for cramps?**[ ]**  Over the counter **[ ]** Prescription medication |
| How old were you when you had your first period?  |
| **Your Pregnancy History** |
| How many times have you been pregnant? How many miscarriages have you had? How many abortions have you had?­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many tubal pregnancies have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many living children do you have? Has it been more than 21 days since your last delivery? \_\_\_\_\_\_\_\_\_\_List the dates of any tubal pregnancies: Are you breast-feeding now? [ ]  Yes [ ]  No |
| **Your Gynecological History**Have you ever had a Pap test?[ ]  Yes [ ]  No |
| When was your last Pap test done?Month Year  |
| **Yes** | **No** | **Have you had any of the following?** |
| **[ ]**  | **[ ]**  | Abnormal Pap test. If yes, when?  |
| **[ ]**  | **[ ]**  | Treatment for abnormal pap  |
| **[ ]**  | **[ ]**  | Ovary problems |
| **[ ]**  | **[ ]**  | Uterus problems or uterine fibroids |
| **[ ]**  | **[ ]**  | Pelvic Inflammatory Disease (PID) |
| **[ ]**  | **[ ]**  | Pain or other problems with sex |
| **[ ]**  | **[ ]**  | Vaginal discharge that itches/burns or has a bad odor |
| **[ ]**  | **[ ]**  | Have you had gender affirming surgery? If so, describe:  |
| **Your Birth Control History** |
| **Yes** | **No** |  |
| **[ ]**  | **[ ]**  | Are you using a method of birth control now? If yes, what method?  |
| **[ ]**  | **[ ]**  | Have you used any birth control methods that you have had a problem with? What method/s?  |
| **[ ]**  | **[ ]**  | In the last 5 days or since your last period, have you had sex without birth control? (condoms are birth control) |