Name: ______________________________________

Today's Date: ______/______/______

Date of Birth: ______/______/______

HEALTH HISTORY

What are your pronouns? Please circle all that apply. he/him she/her they/them other:_______

What is your gender identity? Please circle all that apply. Female (Cisgender) Male (Cisgender) Transman/Transmasculine Transwoman/Transfeminine Genderqueer Non-binary Gender Non-conforming Agender Choose not to disclose Other (Not listed): ______________

What is your assigned sex at birth? Please circle. Male Female Intersex

What is your current legal sex? Please circle. M (male) F(female) X (other)

Medications: *Do you take any herbal supplements, vitamins, or medications (prescribed or over-the-counter)? If yes, please list in table below:*

Name of Medication	Dose	Frequency	Reason for taking
Ex: Omeprazole (Prilosec)	40mg (2 tablets)	In the am, before meals	Stomach ulcers

Allergies: Please circle all that apply (and any other allergies not listed) and reaction:

Medications/antibiotics, substances, foods, etc.	Reaction: ex. hives, facial swelling, anaphylaxis, difficulty breathing
Latex Shellfish Sulfa Drugs Eggs Nuts (which?)	

Have you had the following immunizations? *(Please give an approximate month and year)*:

Hepatitis A ________ Hepatitis B _________ (Typically given in a 2 or 3 dose series, sometimes combined)

HPV/Gardasil ________ _________ __________ (Recommended as a three-dose series for young teenagers)

Influenza______________ Approximate month if vaccinated within the last year (Recommended yearly)

COVID-19__________ ___________ ___________ Approximate month of your last shot after full vaccination

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Past Medical History *This is referring to YOUR current or past medical problems*

	YES	NO		YES	NO
Anemia			Breast biopsy or breast surgery		
Asthma, last attack:			Radiation therapy		
Cancer – what type:			Lupus or Rheumatoid Arthritis		
High blood pressure			Liver disease/ Hepatitis		
Stroke			Osteoporosis		
Heart disease			Kidney disease		
Heart attack			Thyroid disease		
Blood clots in leg (DVT) or lung (PE)			Depression		
Bleeding or clotting disorder			Anxiety		
Headaches/Migraines			Mood Disorder		
Seizures/Epilepsy			PMS/PMDD		
Diabetes			Endometriosis		
Uterine Fibroid(s)			Pelvic Inflammatory Disease (PID):		
Ovarian cyst(s)			Porphyria		
Breast mass			**Additional diagnoses, illnesses, conditions not listed:**		
History of STI (please circle which): Chlamydia Gonorrhea Herpes HIV Syphilis Warts/HPV					

Family Medical History: *Has a first-degree blood relative (parents, siblings, grandparents, maternal or paternal aunts or uncles) had any of the following?*

	YES	NO	**Relative** (Please specify which side of the family)
Cancer (uterine, ovarian, breast, colon, other) – **please list cancer type:**			
Diabetes			
High blood pressure			
Heart disease			
Heart attack			
Stroke			
Blood clots in legs or lungs			
Bleeding or clotting disorder			
Osteoporosis			

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Surgical History: *Have you ever had surgery*? If yes, please list surgery and date:

Surgery	Month/Year
Example: wisdom teeth removal	*August 2010*

Menstrual History:

First day of last menstrual period: ______/______/______ *please circle which:* definite estimate

Are your periods regular "like clockwork"? **Y / N**

How many days between start of one period to the next, typically? (ex. 28-32 days):______________

How many days does your period last? (ex. 3-4 days):___________

Flow (circle one): Light / Moderate / Heavy Age at first period: __________________

Do you experience painful, crampy periods? **Y / N** Age that this began:_________________

Any unexplained vaginal bleeding? **Y / N** If yes please describe: ________________

Have you experienced menopause? **Y / N** If yes, approximate your last period above and skip to OB/GYN history

Contraceptive History:

Are you planning to become pregnant in the next 12 months? **Y / N**

If no, please circle the method(s) you are **currently** using to prevent pregnancy:

Abstinence	Condoms	Emergency contraception Ella (Rx) or Plan B (OTC)?	Diaphragm/Cervical cap/ Sponge/Spermicide	Fertility Awareness Method (Rhythm)
Implant (Nexplanon)	Injection (Depo Shot)	Hormonal IUD (Mirena, Liletta, Kyleena,Skyla)	Copper IUD (Paragard)	Patch
Pill	Ring (NuvaRing)	Same sex partner	Tubal Sterilization	Vasectomy
Withdrawal (Pull Out)	Partner method	I am neither trying nor preventing pregnancy; would welcome a pregnancy if it happened	Other (please specify):	

Which (if any) of these above methods have you tried in the past?

Was there a particular side effect, challenge, or reason for stopping and/or switching methods?

If yes please describe below (or put an "X" over the methods you've tried with a note or description):

____

Name: ____ Date of Birth: ______/______/______

OB/GYN History: *(if you have a uterus)*

Have you been pregnant before? **Y / N** ***If no and you have a uterus, skip to section under black line***

Total # of pregnancies (including a current pregnancy): _________

# of vaginal births (at term, 37+ weeks): _________________ # of term C-sections: _____________

# of premature births (before 37 weeks): _____How many weeks?_______(specify if twins/multiples)

# of abortions and/or miscarriages (please specify if 16+ weeks): ___________ # of weeks:__________

# of living children:__________________

Any pregnancy, postpartum, or birth-related complications (such as hemorrhage)? **Y / N**

Have you ever been diagnosed with an ectopic pregnancy, a molar pregnancy or abnormally growing pregnancy tissue? If so, please circle which one(s). **Y / N**

Are you currently breastfeeding? **Y / N**

Have you ever had a PAP Smear? **Y / N**

If yes, Approximate month/year of most recent PAP:__________________________

Was it normal? Please circle. **Yes** **No** **Unsure**

Have you ever had an abnormal PAP? If so, Approximate month/year:________________________

Have you ever had surgery on your cervix, a colposcopy, cryotherapy or LEEP? **Y / N**

Have you ever had surgery to your uterus, fallopian tubes, or ovaries? **Y / N**

Have you ever been diagnosed with pelvic inflammatory disease (PID)? **Y / N**

Social History

Do you currently smoke tobacco? Y / N If no, are you a former tobacco smoker? Y / N

Do you currently vape or use nicotine/smokeless tobacco products? Y / N

How many each day? _____ Smoked how many years? _____ Are you interested in quitting? Y / N

Sexual Health Risk Assessment: (STIs = Sexually transmitted infections such as chlamydia, gonorrhea, HIV, syphilis)

Do your partners typically have a penis or a vagina? penis vagina intersex other (please describe):

What body parts are involved in the sex you have with partners? *(circle one or multiple)*

Gave oral sex Anal insertive sex Sex involving hands/fingers

Received oral sex Anal receptive sex Vaginal sex

Do you currently have (circle): one mutually monogamous partner more than one partner

partner has (or may have) other partners

Are you having symptoms? Y / N If yes, please describe: _________________________________

Have you heard of a partner who has an STI? Y / N If yes, which?____________________________

Have you been screened for STIs before? Y / N If yes, most recent testing date:_______________

How many partners since your last STI screen? ________ When did you last have sex? __________________

How often do you use condoms or other barrier methods? *(circle)* ALWAYS SOMETIMES RARELY NEVER

Were you born during 1945 - 1965? Y / N *(if so, it's recommended your have 1 time hepatitis C screening)*

Have you or any partners had sex for drugs, shelter/safety, food or money? Y / N

Have you or any partners ever shared needles for drugs, medications, tattoos or piercings? Y / N