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| **CLIENT HEALTH HISTORY** | Staff Comment |
| **Reason for visit today🡪**  | Explain |  |
| **YES** | **NO** |  | Do you have any allergies to food, medication, latex?  List:  |  |
| **YES** | **NO** |  | Are you feeling ill or concerned with your health?? □Covid symptoms □ fever, chills, and fatigue □weight loss or gain of >10 lbs. □ currently being treated for any illness or condition? □other |  |
| **YES** | **NO** |  | Do you have a family doctor?? Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  **YES** | **NO** |  | Are you taking any medication (over the counter, vitamins, or prescription)? List: |  |
| **YES** | **NO** |  | Have you had or are you planning a **surgery** or **hospitalization**? What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **YES** | **NO** |  | Have you had Covid? If yes, what month and year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **YES** | **NO**  | **???** |  Are your immunizations up to date?  |  |
| **PSYCHOLOGICAL HISTORY** |
| **YE** | **NO** |  | Do you suffer from: □ depression □anxiety □emotional distress □ PTSD □other |  |
| **NEUROLOGICAL HISTORY** |
| **YES** | **NO** |  | Do you experience: □Headache □headache with aura □double vision□ flashing lights/wavy lines □numbness/weakness □speech problems □other |  |
| **YES** | **NO** |  | Do you have seizures? List frequency and type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **YES** | **NO** |  | Do you have hearing problems or vision problems other than glasses? |  |
| **CARDIOVASCULAR / HEMATOLOGICAL** |
| **YEs** | **NO** |  | Do you have or have a history of: □heart murmur □ high cholesterol  □ heart attack □ stroke □CHF □ A-fib/V-fib □other |  |
| **YES** | **NO** |  | Do you have or have a history of: □anemia □excessive bleeding □ blood clotting disorder □ other |  |
| **RESPIRATORY HISTORY** |
| **YES**  | **NO** |  | Do you have or have a history of: □ asthma □ COPD □ chronic bronchitis □ Tuberculosis □ exposure to Tuberculosis □ sleep apnea or concerns □other |  |
| **Other pertinent History** |
| **YES** | **NO** |  | Do you have or have a history of: □ stomach/bowel problems □constipation □ liver problems □ diabetes □ osteoporosis □arthritis □ autoimmune disorder □thyroid disorder □ genetic disorder □ other |  |
| **YES** | **NO** |  | Do you have or have a history of: □ bladder/ kidney problems □frequent UTI □incontinence □ burning with urination□ Blood in urine □ other |  |
| **YES** | **NO** |  | Do you have skin concerns? □ acne □eczema □psoriasis □cold sores □open skin at groin □ other □change in moles □ rash other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| **FAMILY HEALTH HISTORY** |
| **YES** | **NO** |  | I am adopted and I do not know my family health history. |  |
| **Check all that apply🡪** | Has any of your parents or siblings had any of the following? □ diabetes (type 1,2, or gestational) □thyroid problems □genetic problems □ heart attack □ stroke before age 50 □high blood pressing □high cholesterol □ blood clotting disorders □osteoporosis □endometriosis □ Polycystic Ovarian Syndrome □ drug abuse □alcohol abuse □ mental illness □none □ other |  |
| **YES** | **NO** |  | Is there a family history of cancer? □ breast □ colon □ovarian □cervical □ skin □ lung □pancreatic □ other |  |
|  |  |  | Please indicate what family member had the above listed cancer: |  |
| **Please list any other health concerns you would like addressed by the provider or the nurse:** |

**\*\*\*\*\* Page 3 is for FEMALE only**

**\*\*\*\*\*\* Page 4 is for MALE only**

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| **BASIC INFORMATION** | **Gender Affirmation: circle 🡪 Female / Male / See Below****Sexual Identity: circle 🡪Straight / Gay / Bisexual / See Below**~Additional **optional** responses below will help us better serve your needs**~** |
| **OPTIONAL\*\*****(Gold Boxes)****DETAILED INFORMAITON**to help us serve you better 🡪  | **How do you describe your current gender identity?** (Check one) □ Male □ Female □ Trans Male/Trans Man/ Female-to-Male (FTM) □ Trans Female/Trans Woman/ Male-to-Female (MTF) □ Genderqueer □ Genderfluid □ Androgynous □Non-binary □ Other \_\_\_\_\_\_\_\_\_\_ □ Choose not to disclose |
| **How do you describe your current sexual identity**? □Straight □ Gay □ Lesbian □ Queer  □Pansexual □ Questioning □Asexual □Two-Spirit □ other (please list)\_\_\_\_\_\_\_□ Choose not to disclose |
| **Gender at birth? □** Male □ Female □ other/intersex |
| **Have had or in processes of:** □gender reassignment surgeries □ hormone therapy related to gender reassignment □n/a |
| **Physically attracted to: □** men □women □other  **Emotionally attracted to: □** men □women □other |
|  | **CONTRACEPTIVE**  |
|  **Check all that apply 🡪** |  **What method of birth control have you or your partner used in the past? □None****□ Abstinence □Natural Family Planning □Withdrawal □Spermicide (foam)****□Condoms □ Diaphragm □Birth Control Pills □Vaginal Ring □Patch □Depo-Provera □Implant □IUD □Emergency Contraception □Tubal Ligation □Vasectomy □Hysterectomy** |
| **YES** | **NO** |  | Are you interested in education and tools for fertility awareness-based methods of birth control? (FABM) |
|  **Answer required 🡪** | **What method are you using now?** **List: \_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_ Do you want to change your method?** Yes/No |
| **YES** | **NO** |  | Do you need emergency contraception or education about EC? |
|  | **OB / GYN** |
| **YES** | **NO** |  | Have you noticed any signs of vaginal infection? □none □ Burning □ Discharge □ Itching □ Odor □ Bumps/Sores □ Pain with sex |
|  **Answer Required 🡪** | **How old were you when you first started your period? Age: \_\_\_\_\_\_\_\_\_\_\_\_** |
|  **Answer Required** **🡪**  | **When was the first day of your last period? Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Check all that apply 🡪** | **Menstrual History: □ monthly periods □ normal periods □ spotting between periods □ skipped periods □ no periods □ heavy flow □ cramping □bloating** **□ emotional changes □ skin/complexion changes**  |
| **YES** | **NO** |  | Do you have: □ uterine fibroids □polycystic ovarian syndrome □ endometriosis □pain with intercourse □ bleeding with intercourse □difficulty conceiving □ none |
| **YES** | **NO** | **N/A** | Have you ever had a pap**? Date of most recent pap if applicable**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Follow up to abnormal pap: □ colposcopy □ cryotherapy □ LEEP □ no intervention □ N/ |
| **YES** | **NO** |  | Performs self-breast exam. How often? □ weekly □ monthly If concerns, check all that apply: □ tenderness □ lumps □ nipple dimpling □ skin changes |
| **YES**  | **NO** |  | Have you ever been pregnant? |
|  **Answer if applicable 🡪** | **Date of last delivery: \_\_\_\_\_ Total number of pregnancies: \_\_\_\_\_** **Number of live births: \_\_\_\_\_**  |
| **Number of tubal pregnancies: \_\_\_\_** **Number of miscarriages: \_\_\_\_ Number of abortions: \_\_\_\_\_\_** |
| **YES** | **NO** |  | Are you breast feeding/chest feeding? |
|  |  |  | Please list problems with pregnancy if applicable: |

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| **Gender at birth?** □ Male □ Female □ other/intersex |
| **Have had or in processes of:** □gender reassignment surgeries □ hormone therapy □n/a |
| **Physically attracted to:** □ men □women □other**Emotionally attracted to:** □ men □women □other |
|  | **Reproductive/Urinary** |
| **YES** | **NO** |  | Have you had a vasectomy? |
| **🡪** | What is your partners method of pregnancy prevention? List: |
| **YES** | **NO** |  | Have you ever fathered a child? How many?? \_\_\_\_\_ |
| **YES** | **NO** |  | Do you do regular testicular self-exams? |
| **YES** | **NO** |  | Have you noticed any of the following? □ bumps/sores □ abdominal pain □ burning □ discharge □ itching □ odor □ scrotal pain/swelling □ pain with intercourse □Skin changes □infertility □none |
|  |  |  |  |