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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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| --- | --- | --- | --- |
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| **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 |
|  |  |  |  |