

Medical History

Name _____ Date of Birth _____ Today's Date _____

Reason for today's visit: _____

The following information will help us provide you with the highest quality care.
Please fill out this health history as completely as possible. Thank you.

Medical History

Do you now have or have you had any of the following? Check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia/blood disorder | <input type="checkbox"/> Sinusitis/allergies | <input type="checkbox"/> Surgery on reproductive organs |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Bleeding problems/blood disease | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood clots in veins | <input type="checkbox"/> Anesthesia complication | <input type="checkbox"/> Glaucoma/eye problems |
| <input type="checkbox"/> Heart problems/surgery | <input type="checkbox"/> Blurred vision/blackouts | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Fainting | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Severe varicose veins | <input type="checkbox"/> Hepatitis/liver disease | <input type="checkbox"/> Drug addiction |
| <input type="checkbox"/> Rhogam injection/Rh negative | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Suicidal thoughts/attempt |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Panic/anxiety disorder |
| <input type="checkbox"/> Nasal polyps | <input type="checkbox"/> Gastric Bypass surgery | <input type="checkbox"/> Have you ever been physically assaulted? |
| <input type="checkbox"/> Asthma/shortness of breath | <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Breast problems | <input type="checkbox"/> _____ |

Please list any allergies you have, and their reactions: _____

Are you currently taking any medications? Please list any prescriptions, supplements, vitamins or over-the-counter medications:

Do you have or have you had any medical problems? What are they? _____

Are you currently breastfeeding? yes no

Family History

*Is there a family history of any of the following?
If so, please list which family member was affected.*

- | | | | |
|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you adopted? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ovarian cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other cancer |
| Explain: _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis (brittle bones) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of inheritable disease (Tay-Sachs, sickle cell anemia, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was your mother given DES to prevent miscarriage? |
| Self-identified Ethnicity or Race: _____ | | | |

(we ask to be able to get grant funding from foundations)

Social History

Yes No

- Do you exercise regularly? Type and amount per week: _____
- Do you smoke? How many cigarettes per day? _____
How many years have you smoked? _____
- Were you previously a smoker?
- Do you drink alcohol? How many drinks per week? _____
- Do you use drugs for recreation? Please list: _____

- How often do you use? _____ times per day/week/month
- Is vein access a problem for you?
- Do you think you may have a problem with drugs or alcohol?
- Would you like referrals or additional information for any of the following?*
- | | | | | |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| Yes | No | | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | Domestic violence | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Rape/Sexual assault | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or drug dependency | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |

If you are here for a termination...

Do you feel that you have emotional support? yes no

How are you feeling about your decision to have an abortion?

- Very sure Sure Unsure

CEDAR RIVER CLINICS
 Renton Tacoma Yakima

Current Symptoms

Are you currently experiencing any of the following? How long? Check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Irregular bleeding | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Lower backache | <input type="checkbox"/> Pain during or after intercourse | <input type="checkbox"/> Pain/burning with urination |
| <input type="checkbox"/> Vaginal burning | <input type="checkbox"/> Bleeding after intercourse | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Pain during or after orgasm | <input type="checkbox"/> Small amounts of urine |
| <input type="checkbox"/> Unusual discharge | <input type="checkbox"/> Rash/bumps/sores in genital area | <input type="checkbox"/> Bloody urine |

Has your sexual partner had any of the symptoms listed above? Which ones? _____

How long? _____

Gynecological History

Do you have or have you had any of the following? Check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal Pap smear result | <input type="checkbox"/> Abnormal uterus shape/position | <input type="checkbox"/> Bacterial vaginosis (BV) |
| <input type="checkbox"/> Biopsy/colposcopy | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Breast lump/cancer |
| <input type="checkbox"/> Laparoscopy/laparotomy | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) | <input type="checkbox"/> Infertility problems |
| <input type="checkbox"/> Cervical/uterine cancer | <input type="checkbox"/> Chlamydia or Gonorrhea | <input type="checkbox"/> Urinary tract infection (UTI) |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> HPV/genital warts | <input type="checkbox"/> Pre-eclampsia/toxemia |
| <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Date of last Pap smear: _____ |
| <input type="checkbox"/> Endometritis (infection of the | <input type="checkbox"/> Vaginal infection | <input type="checkbox"/> Have you had the HPV vaccine? How many doses? _____ |

Please list the total number of:

Pregnancy History

If pregnant, is this your first pregnancy? <input type="checkbox"/> yes <input type="checkbox"/> no	Pregnancies	Births	Premature Deliveries	Abortions	Miscarriages	Living Children	Cesarean sections	Ectopic	Genetic Defects

Please explain any pregnancy complication:

Menstrual History

Age at first period: _____

Date last period began: _____

Was it a normal period? yes no If not, please explain:

Your periods are: regular irregular absent painful

Your periods come about every _____ weeks for _____ days.

On heavy days, number of pads/tampons used daily: _____

Any recent changes in your menstrual pattern? yes no

If so, what changes? _____

Contraceptive History

What, if any, form of birth control are you currently using?

Any problems with it? _____

Do you want to change your method of birth control? If so, which method(s) are you interested in? _____

Have you used any of these contraceptives in the past?

- | | | | |
|--|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> The Pill | <input type="checkbox"/> Depo Provera | <input type="checkbox"/> IUD | <input type="checkbox"/> Male Condom |
| <input type="checkbox"/> Female Condom | <input type="checkbox"/> Foam/Jelly | <input type="checkbox"/> Sponge | <input type="checkbox"/> Cervical cap |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Rhythm/Fertility Awareness Method | | |
| <input type="checkbox"/> ECT/Emergency Contraceptive | <input type="checkbox"/> The Patch | <input type="checkbox"/> Vaginal Ring | |
| <input type="checkbox"/> Withdrawal | | | |

Any problems with them? _____

Do you want children in the future? yes no unsure

Well Woman

Do you think you may be pregnant? yes no

Are you currently trying to become pregnant? yes no

Client Signature

Date

Interpreter Signature

Date

Interpreter Agency

Sexual History

At what age did you first have sexual intercourse? _____

Are you currently having sex? yes no

Check all that apply: vaginal oral anal

Are your sexual partners male female both

How many partners have you had in the past 60 days? _____

Has your partner been sexual with anyone else in the last 12 months?

Yes Not Sure No

Yes No Have you...?

Had a new sex partner in the last 60 days?

Used a condom the last time you had intercourse?