Client name: _____

PATIENT IDENTIFICATION

Today's date: ____ /____ /_____ Birth date: ____ /____ /_____ Age: _____

List any medications that you are currently taking: _____

_____

List any medications, foods, latex, etc. that you are allergic to and the reaction you have: _____

_____

Nutritional History

Yes ☐ No ☐ Are there changes you would like to make to your diet? If yes, describe: _____
Yes ☐ No ☐ Do you exercise regularly? Describe: _____

List any supplements, herbs, or weight loss products you use: _____

Over the last 12 months, have you been bothered by the following problems?

Yes ☐ No ☐ I worried that my food would run out before I had money to buy more.
Yes ☐ No ☐ The food that I bought just did not last and I did not have money to buy more.
Yes ☐ No ☐ I worried that I would not have the money to pay rent.
Yes ☐ No ☐ I worried that I would not have the money to pay for utilities (water bill, heat, electricity).

Yes ☐ No ☐ Tobacco use (if yes please answer) ☐Former ☐Current
Type of tobacco: _____ Amount per day: _____
Year quit: ____ /____ /_____
Yes ☐ No ☐ Alcohol use (if yes please answer) Drinks per week: # _____
Yes ☐ No ☐ Drug use (if yes please answer) Types and frequency_____

Immunizations (list dates)

Yes ☐ **No** ☐ Are you up to date on immunizations?
Yes ☐ **No** ☐ HPV (Human Papillomavirus) ____ /____ /_____
Yes ☐ **No** ☐ Influenza (Flu) ____ /____ /_____

Your Family History

☐ Check here if you do not know your family history.
Have your grandparents, parents, or brothers/sisters had any of the following? If yes, list who and at what age.

Yes ☐ **No** ☐ Blood clots in arms/legs/chest _____
Yes ☐ **No** ☐ Bleeding problems _____
Yes ☐ **No** ☐ High blood pressure (hypertension) _____
Yes ☐ **No** ☐ High cholesterol/triglycerides _____
Yes ☐ **No** ☐ Breast/ovarian/uterine/colon cancer _____
Yes ☐ **No** ☐ Other Cancer _____
Yes ☐ **No** ☐ Heart attack _____
Yes ☐ **No** ☐ Stroke _____
Yes ☐ **No** ☐ Diabetes _____
Yes ☐ **No** ☐ Birth defects _____
Yes ☐ **No** ☐ Alcohol/drug misuse or abuse _____

Your Medical History

Yes ☐ **No** ☐ Have you been to the ER or hospitalized in the last year?
Please list: _____
Do you have now or have you had any of the following?
Yes ☐ **No** ☐ Asthma
Yes ☐ **No** ☐ Heart disease or high blood pressure (hypertension)
Yes ☐ **No** ☐ Heart attack or stroke
Yes ☐ **No** ☐ High cholesterol/triglycerides
Yes ☐ **No** ☐ Migraines or frequent headaches
Please describe: _____
Yes ☐ **No** ☐ Visual changes or numbness
Yes ☐ **No** ☐ Lupus (SLE)
Yes ☐ **No** ☐ Cancer
Please list type and year diagnosed: _____
Yes ☐ **No** ☐ Blood problems (Sickle cell anemia, hemophilia, low iron)
Yes ☐ **No** ☐ Have you or your partner(s) ever had a blood transfusion, tissue/organ transplant, or artificial insemination?

Client name: _____

Your Medical History Continued

Yes ☐ **No** ☐ Inflammatory bowel disease (IBD)
Yes ☐ **No** ☐ Gall bladder disease
Yes ☐ **No** ☐ Surgery Please list: _____
Yes ☐ **No** ☐ Breast disease
Yes ☐ **No** ☐ Mammogram Date of last mammogram: ____ /____ /_____
Yes ☐ **No** ☐ Kidney or bladder problems
Yes ☐ **No** ☐ Liver disease (hepatitis, mono, jaundice, cirrhosis)
Yes ☐ **No** ☐ Diabetes
Yes ☐ **No** ☐ Epilepsy, seizures or convulsions
Yes ☐ **No** ☐ Depression or other mental health concerns
Yes ☐ **No** ☐ Have you had gender affirming surgery?

Your Sexual and Reproductive Health

Have you ever had any of the following sexually transmitted infections?

Yes ☐ **No** ☐ Chlamydia
Yes ☐ **No** ☐ Gonorrhea
Yes ☐ **No** ☐ Genital warts/Human Papillomavirus (HPV)
Yes ☐ **No** ☐ Syphilis
Yes ☐ **No** ☐ Herpes
Yes ☐ **No** ☐ Trichomoniasis
Yes ☐ **No** ☐ Non-gonococcal urethritis (NGU)
Yes ☐ **No** ☐ Have you or your sexual partner(s) ever used needles to shoot drugs?
Yes ☐ **No** ☐ Have you received a tattoo in an unregulated or unsterile environment?
Yes ☐ **No** ☐ Have you or your sexual partner(s) ever exchanged sex for drugs or money?
Yes ☐ **No** ☐ Do you use condoms (either external or internal)
If yes, how often: ☐ Sometimes ☐ Always
Yes ☐ **No** ☐ Have you ever been tested for HIV? When? ____ /____ /_____
Yes ☐ **No** ☐ Have you had a positive HIV test result?
Yes ☐ **No** ☐ Have you had a new partner in the past 2 months?
How many lifetime sexual partners have you had? # _____
Yes ☐ **No** ☐ Are your sex partners ☐male ☐female ☐both ☐transgender ☐transsexual ☐intersex ☐non-binary ☐other
Yes ☐ **No** ☐ Do you have vaginal sex?
Yes ☐ **No** ☐ Do you have oral sex? Check all that apply.
☐Receive ☐Give
Yes ☐ **No** ☐ Do you have anal sex? Check all that apply.
☐ Insertive/Top ☐ Receptive/Bottom ☐ Both
When was the last time you had sex? ____ /____ /_____
Yes ☐ **No** ☐ Have any male partners had sex with other men?
Yes ☐ **No** ☐ Are any of your sex partners living with HIV?
Yes ☐ **No** ☐ Do you have a trusted adult to talk to about things like healthy relationships, sex, and birth control?
Yes ☐ **No** ☐ Has a partner ever forced you to do something sexually that you did not want to do or refused your request to use condoms?
Yes ☐ **No** ☐ Does your partner support your decision about when or if you want to become pregnant?

*Complete these questions <u>only</u> if you are **male**, **assigned male at birth**, or (male to female) **MTF***

Your Urological History

Yes ☐ **No** ☐ Do you have abnormal discharge from the penis?
Yes ☐ **No** ☐ Do you have now or in the past a lesion, sore, or lump on your penis, scrotum or testicles?
Yes ☐ **No** ☐ Have you ever had pain with sex? When: _____

Your Reproductive History

How many children do you have? # _____
Yes ☐ **No** ☐ Do you think you might want to have (more) children at some point?
When do you think that might be? _____
How important is it to you to prevent pregnancy? _____
Yes ☐ **No** ☐ Are you using birth control?
If so, which method are you using: _____

Client name: _____

*Complete these questions <u>only</u> if you are **female**, **assigned female at birth**, or female to male (**FTM**)*

<u>Your Menstrual History</u>

Please share the date of your last menstrual period (first day): ____ /____ /_____

Yes ☐ **No** ☐ Was your last menstrual period normal?

Yes ☐ **No** ☐ Do you have a period every month?

Is the flow: ☐ light ☐ medium ☐ heavy

Yes ☐ **No** ☐ Do you bleed between periods?

Yes ☐ **No** ☐ Do you have cramps with your periods?

Yes ☐ **No** ☐ Do you take medication for cramps? What type: _____

How old were you when you had your first period? _____

<u>Your Pregnancy History</u>

Yes ☐ **No** ☐ Are you planning a pregnancy within the next year?

How many times have you been pregnant? _____

List the dates that you gave birth: ____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____
____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____

How many living children do you have? # _____

List the dates of any miscarriages or abortions: ____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____
____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____

List the dates of any tubal pregnancies: ____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____
____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____ ____ /____ /_____

Yes ☐ **No** ☐ Are you breastfeeding now?

Yes ☐ **No** ☐ Have you had a baby that weighed less than 5 ½ pounds?

Yes ☐ **No** ☐ Have you had a baby that weighed more than 9 pounds?

Yes ☐ **No** ☐ During any pregnancy, did you have high blood pressure, diabetes, or a baby with birth defects?

<u>Your Gynecological History</u>

When was your last Pap or HPV screening done? ____ /____ /_____

Have you had any of the following?

Yes ☐ **No** ☐ Abnormal Pap or HPV result? If yes, when? ____ /____ /_____

Yes ☐ **No** ☐ Colposcopy, biopsy or treatment of your cervix?

If yes, when? ____ /____ /_____

Yes ☐ **No** ☐ Ovary problems

Yes ☐ **No** ☐ Uterus problems or uterine fibroids

Yes ☐ **No** ☐ Pelvic Inflammatory Disease (PID)

Yes ☐ **No** ☐ Pain or other problems with sex

Yes ☐ **No** ☐ Vaginal infections (yeast or bacterial)

<u>Your Birth Control History</u>

Yes ☐ **No** ☐ Are you planning a pregnancy within the next year?

How important is it to you to prevent pregnancy? _____

Yes ☐ **No** ☐ Are you using a method of birth control now?

If yes, what method? _____

Yes ☐ **No** ☐ Have you used a birth control method that you had a problem with?

Please describe: _____

Yes ☐ **No** ☐ In the last 5 days or since your last period, have you had sex without birth control or did your method of birth control fail (condoms are birth control)?

Client Signature: _____ Date: ____ /____ /_____