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| --- | --- |
| **Reason for visit today🡪**  | **Explain:** (Example: Testing, Treatment, Contraception, Annual Exam, Other health concern) |
| **YES** | **NO** |  | Do you have allergies to food, medication, environment, or latex?List:  |
| **YES** | **NO** |  | Are you feeling ill today? Covid symptom?Explain:  |
| **YES** | **NO** |  | Do you have a family doctor/primary care physician?Name & Clinic: |
| **YES** | **NO** |  | Are you taking any over the counter medication, vitamins, or health supplements: (Non-Prescription) |
| **YES** | **NO** |  | Have you had recent surgery or hospitalization? Planning a procedure?Explain: |
| **YES** | **NO** |  | Have you had Covid? If yes, what month and year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **YES** | **NO** |  | Are your immunizations up to date? Unsure? |

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| **My Health:**  | **Current Problem** | **Past Problem** | **Prescription****Medication** | **My Family History**List family member with the health issue: |
|  | Checkmark (√) | Checkmark (√) | List name/dose of medication  | Example: Parent, Sibling,Grandparent, child, aunt |
| Depression |  |  |  |  |
| Anxiety |  |  |  |  |
| PTSD |  |  |  |  |
| Other mood issue: |  |  |  |  |
| Headache with aura |  |  |  |  |
| Headache without aura |  |  |  |  |
| Double Vision/Flashy lights |  |  |  |  |
| Numbness/weakness |  |  |  |  |
| Speech Problems |  |  |  |  |
| Other neuro issue: |  |  |  |  |
| Hearing Problems |  |  |  |  |
| Vision Problems: |  |  |  |  |
| Cancer: (List) |  |  |  |  |

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|  | **Current Problem****(√)** | **Past****Problem****(√)** | **Prescription****Medication** **Name & Dose** | **My Family History**List family member withThe health issue: |
| Heart murmur |  |  |  |  |
| High cholesterol |  |  |  |  |
| Heart attack |  |  |  |  |
| Stroke |  |  |  |  |
| CHF |  |  |  |  |
| A-fib/V-fib |  |  |  |  |
| Cardiomyopathy |  |  |  |  |
| Other cardiac issue: |  |  |  |  |
| Anemia |  |  |  |  |
| Excessive bleeding |  |  |  |  |
| Clotting disorder |  |  |  |  |
| Other bleeding issue: |  |  |  |  |
| Asthma |  |  |  |  |
| COPD |  |  |  |  |
| TB/Exposure to TB |  |  |  |  |
| Sleep apnea |  |  |  |  |
| Other respiratory issue: |  |  |  |  |
| Stomach-heartburn |  |  |  |  |
| Constipation-Diarrhea |  |  |  |  |
| Liver problems |  |  |  |  |
| Diabetes Type 1/Type 2 |  |  |  |  |
| Osteoporosis |  |  |  |  |
| Arthritis |  |  |  |  |
| Autoimmune Disorder |  |  |  |  |
| Thyroid Disorder |  |  |  |  |
| Genetic Disorder |  |  |  |  |
| Lymphatic Disorder |  |  |  |  |
| Bladder/kidney Condition |  |  |  |  |
| Frequent UTI |  |  |  |  |
| Acne |  |  |  |  |
| Change in Moles |  |  |  |  |
| Eczema |  |  |  |  |
| Gender Reassignment |  |  |  | XXXXXXXXXXXXXXXXXXXXXX |

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| **Males:** | **Females:** |
| **Circle any symptoms you are experiencing:** | **Circle any symptoms you are experiencing:** |
| * Pain with urination
* Bumps/sores
* Itching in the groin
* Odor from the groin
* Rash/skin change
* **No symptoms**
 | * Abdominal pain
* Discharge
* Scrotum pain
* Scrotum swelling
* Pain during sex
* fever
 | * Pain with urination
* Bumps/sores
* Itching in the vulva
* Odor from the vulva
* Rash/skin change
* **No symptoms**
 | * Burning with urination
* Pain with Sex
* Bleeding during/after sex
* Discharge
* Fever
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| **MALE Reproductive** |  | **FEMALE HEALTH HISTORY** |
| **Yes/No** | Have you hada vasectomy? | The age when you had for very first period: \_\_\_\_\_\_yrs. Date of the first day of your last period: \_\_\_\_\_\_\_\_(approx.)Date of most recent pap: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: Normal/Abnormal/NAAbnormal pap procedures: colposcopy – cryotherapy – LEEP – nothing- NA  |
| **Yes/No** | Have you ever fathered a child? |
| I want to apply for the ***Women’s Way*** Program **Yes/No** |
| **FEMALE Reproductive** |  | **Menstrual History (Check all that apply)** |
| Total # pregnancies |  | □ Skipped periods | □ No periods | □ Emotional Change |
| Number of live births |  | □ Spotting between  | □ Bloating | □ Skin changes/acne |
| # of tubal pregnancies |  | □ Unpredictable periods | □ Cramping |  |
| # of miscarriages |  |  |  |  |
| # of abortions |  | **GYN History (Check all that apply)** |
| Date of last delivery: | Uterine fibroids | Polycystic ovarian syndrome |
| Complications? Problems? | Endometriosis | Pain with intercourse |
| Are you breastfeeding: Yes/No |  | Difficulty conceiving | Other\_\_\_\_\_\_\_\_\_\_\_ |

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| **Basic Information** |
|  **My gender at birth:** Male - Female**My sexual Orientation: *Decline to answer*** – Straight – Gay – Bisexual – other - unknown |
| **My gender Identity: *Decline to answer*** – male – female – transgender Male – transgender female – Gender-queer**I am sexually attracted to: *Decline to answer*** – males- females – both – neither |

**CONTRACEPTIVE HISTORY** **Method I am using now \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_ Do You want to change? Yes/No** |
| **Methods I have used in the past:**  | Nothing | Withdrawal | Foams | Gels Abstinence | Condom | Patch |
| Pills | Vaginal Ring | Depo Shot | Implant |  IUD | Emergency contraception | Tubal Ligation | Sterilization |
| Do you need Emergency contraception today? **Yes/ No** To have on hand: **Yes/No** |
| Are you interested in learning more about Fertility Based Awareness (Natural Family Planning)? **Yes/No** |