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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: |
|  | Check  mark (√) | Check  mark (√) | 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 with  The 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 had  a 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/NA  Abnormal 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** | | | | | | | | | | |