Female - MEDICAL HEALTH HISTORY

This medical record is ***confidential*** and will not be released to anyone except as may be required by law.

Barron County DHHS-PH Programs
335 E Monroe Ave Room 338
Barron WI 54812
715-537-5691- Fax: 715-537-6274

Client Name:_____
Client No._____
DATE: _____/_____/_____

Name:_____ Date of Birth ____/____/_____ Age _____
(Last) (First) (MI) mm / dd / yyyy
Please call me (preferred name) _____ Preferred gender: He_____ She_____ Other: _____
Reason for visit_____
Have you or your partner recently traveled to a region with known Zika or Ebola transmission? ____ Yes _____ No If yes, Where: _____

Please check if you are allergic to:
□Penicillin □Iodine □Zithromax □Doxycycline □Sulfa □Metal □Rocephin □Tetracycline □Latex
□Amoxicillin □Local anesthetic □ No Allergies □Other(s): _____

List medications, vitamins, over the counter drugs, and/or herbs you take:_____
Have you recently taken antibiotics Yes No If yes, when?: _____ for what?: _____ what kind?: _____

MENSTRUAL HISTORY

Day Last period began: _____ Was it Normal? ___Yes ___No
Do you have bad cramps? ____ Yes ____ No
Do you bleed heavy? ____ Yes ____ No Age when periods started: _____
Have you had sex since your period? ____Yes ____ No

SEXUAL HISTORY

Have you ever had sex? ____Yes ____ No
Have you or your partner had more than one sexual partner in your lifetime? ___Yes ___No
Have you had a new partner or more than one partner in the last 90 days? __ yes __ no __don't know
Has your partner(s) had a new sex partner or more than one partner in the last 90 days? __yes __no __don't know
Have you ever engaged in a sexual activity where you felt you couldn't say no? ___yes ___no
Check if you have: ____vaginal sex ____ oral sex ____ anal sex ____ sex with men ____ sex with women ____ sex with both
Check if you have ever had: ____ Chlamydia _____ Gonorrhea _____HPV/warts ____ Herpes _____Syphilis
Have you or your partner(s) used IV drugs? ___Yes ___ No ____ Don't know
Have you had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days? __Yes __ No
Has your partner had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days? _Yes_ No _ Don't know

PREGNANCY

(If never been pregnant – go to next section). →→→→
How many times have you been pregnant? _____
Dates when your pregnancy(s) ended _____
_____
Are you breastfeeding? ____ Yes ____ No

REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? ___Yes___ No
How many children do you hope to have? _____
How long do you plan to wait until you (next) become pregnant?___
_____
What do you plan to do until you are ready to get pregnant?
_____
What can I do today to help you achieve your plan?
_____

CONTRACEPTIVE HISTORY :

Do you *ALWAYS* use condoms? ____ Yes ____ No
Are you using birth control now? ____Yes ____ No If yes, what kind _____
Do you want birth control today? ____Yes ____ No If yes, what kind _____
What kind of birth control have you used in the past? _____
Any problems with those methods?_____
Does your sexual partner(s) agree with your decision to prevent pregnancy and use birth control at this time? ____ Yes ____ No
Has anyone ever done anything to your birth control – i.e. thrown away your pills, patches, rings or taken his condom off before or during sex? ____ Yes ____ No

SOCIAL HISTORY:

Do you smoke cigarettes? ____ Yes ____ No If, YES, _____# per day Do you want to quit? ____Yes ____ No
Do you drink alcohol? ____Yes ____No Do you use street drugs? ____Yes ____ No
Does alcohol/drugs cause problems in your life and/or are others concerned? ____Yes ____ No
Do you feel threatened or afraid of someone in your life? _____ Yes ____ No
Check if you have any concerns about: ____ Date rape _____ Forced/unwanted sex _____ Physical abuse _____Weight
Have you ever received medical care/medications for your mental health? ____Yes ____ No

PAST MEDICAL HISTORY

Have you ever been in the hospital? ____Yes ____ No If yes, why _____
Do you have a doctor? ____Yes ____ No If yes, Doctor's name : _____
List any medical problems: _____
Date of your last pap smear? _____ What Clinic?_____

NURSE TO COMPLETE: BMI_____
Height: _____
Weight: _____
Blood Pressure: _____

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Do you now have or have you ever had:

Yes	No		Yes	No		Yes	No	
___	___	Abnormal pap test	___	___	Endometriosis or ovarian cysts	___	___	Pelvic Infection / PID
___	___	Anemia	___	___	Gall Bladder disease	___	___	Sickle cell anemia, trait of Thalassemi
___	___	Asthma	___	___	Genetic condition	___	___	Stroke
___	___	Breast Surgery or disease	___	___	Heart Disease/High blood pressure	___	___	Thrombophlebitis / blood clot(s)
___	___	Cancer	___	___	High Cholesterol	___	___	Tuberculosis
___	___	Diabetes	___	___	Mono or Hepatitis	___	___	Uterine growth/fibroid
___	___	Diagnosis w/HIV/AIDS	___	___	Mitral Value Prolapse (MVP)	___	___	Seizure disorder / epilepsy
___	___	Blood disorders/Problems with your blood	___	___	DES Exposure	___	___	Bariatric surgery

FAMILY HISTORY

If you are adopted and do not know your family's medical history- go to next section.
Does your mother, father, brother, or sister have any of the following:

Stroke	___Yes	___ No	Diabetes	___ Yes	___ No	Breast Cancer	___ Yes	___ No
Heart Attack	___ Yes	___ No	High Cholesterol	___ Yes	___ No	Ovarian Cancer	___ Yes	___No
Blood Clot	___ Yes	___ No	High Blood Pressure	___ Yes	___ No	Prostate Cancer	___ Yes	___No

REVIEW OF SYSTEMS

A. General

Yes	No	
□	□	Recent weight gain or loss (+25 lbs)
□	□	Reactions to drugs or foods

B. Cardiovascular

Yes	No	
□	□	Chest Pain
□	□	Palpitations
□	□	Varicose Veins

C. Genitourinary

Yes	No	
□	□	Blood in urine
□	□	Pain or burning with urination
□	□	Frequent urination
□	□	Vaginal discharge, itching, irritation, odor
□	□	Bumps, sores, rash in vaginal area
□	□	Have you urinated in past hour?
□	□	Do you have pain with sex?

D. Skin

Yes	No	
□	□	Acne
□	□	Rash/itching
□	□	Night sweats/hot flashes/fever/chills
□	□	Other skin problems

E. Breasts

Yes	No	
□	□	Breast lump
□	□	Breast pain
□	□	Nipple discharge

F. Eye, Ears, Nose, Throat

Yes	No	
□	□	Hearing problems
□	□	Frequent nose bleeds
□	□	Frequent sore throat
□	□	Thyroid problems
□	□	Blurred vision/double vision

G. Respiratory

Yes	No	
□	□	Chronic cough
□	□	Shortness of breath/ breathing problems

H. Neuro/Psych

Yes	No	
□	□	Convulsions / Seizures
□	□	Difficulty with memory or speech
□	□	Emotional problems
□	□	Sadness
□	□	Nervousness
□	□	Numbness/tingling
□	□	Headaches

I. Musculoskeletal

Yes	No	
□	□	Muscle or bone pain
□	□	Back pain

J. Gastrointestinal

Yes	No	
□	□	Abdominal pain
□	□	Nausea/vomiting
□	□	Changes in bowel habits
□	□	Changes in appetite
□	□	Constipation/diarrhea
□	□	Rectal pain or bleeding

K. Immunizations (check all you've had)

□ Tetanus □ Hepatitis A □ Pertussis □ Gardasil/HPV
□ Rubella □ Hepatitis B □ Meningococcal
□ Measles □ Mumps □ Chicken Pox

DIET & EXERCISE:

of servings of the following/per day: _____Dairy ____ Protein _____ Vegetables _____ Fruits ____ Grains
How many meals do you eat a day?_____ How much coffee, tea and soda per day?_____
What do you do for physical activity?_____ How many hours of sleep do you get?_____

To the best of my knowledge the above information is complete and correct.
Patient Signature _____ Date _____/_____/_____
Staff notes: _____
_____
_____

Face-to-Face time:_____ Ed & Counseling Time:_____
Staff Signature: _____ Date _____/_____/_____

 Updated 01/04/2017