UR MEDICINE | HIGHLAND HOSPITAL

{Affix Patient Label}

Initial Medical History Highland Family Planning Program

Family History

Please circle any of the following conditions that family members may have:

Cancer **High Blood Pressure** **Heart attack before age 50** **Blood Clots** **Birth Defects**

High Cholesterol **Diabetes** **Bleeding Problems** **Stroke** **Breast Disease**

Other important illnesses?
List any allergies to food or medicine:
List any medications/vitamins/supplements you are currently taking:

Have you experienced?	**Yes**	**No**
Recent weight changes		
Fatigue		
Swollen glands		
Easily bruise or bleed		
Itchy skin or rashes		
Anemia		

Heart, Lungs, Breast	**Yes**	**No**
Chest pressure/discomfort		
Swelling of feet, ankles, hands		
Palpitations		
Breathing problems		
Breast pain, lumps, discharge		

Stomach, intestinal	**Yes**	**No**
Stomach pain		
Constipation		
Nausea or vomiting		
Frequent diarrhea		
Loss of appetite		

Neurological	**Yes**	**No**
Seizures		
Frequent or recurrent headaches		
Lightheaded or dizzy		

	Yes	**No**
Recurrent mouth sores		
Bleeding gums		
Vision Changes		
Ear Concerns		

Endocrine	**Yes**	**No**
Excessive thirst or urination		
Heat or cold intolerance		
Hormone problem including Thyroid		

Psychiatric	**Yes**	**No**
Nervousness		
Depression		
Sleep problems		

Genitourinary	**Yes**	**No**
Sexual difficulty including pain		
Burning or painful urination		
UTIs (Urinary Tract Infection)		
Kidney Stones		
Vaginal or Penile Discharge/ Pain		

Hospital Care	**Yes**	**No**
Ever had surgery?		
Stayed overnight at the hospital?		

Health History and Habits

		Yes	**No**
Do you eat five servings of fruit and vegetables daily?			
Have you (or anyone close to you) ever felt you had an eating problem (too much or too little)?			
Do you exercise? If yes, how often?			
Do you smoke cigarettes? If yes, how much per day?			
How many times in the past year have you had more than four drinks in a day?			
Have you (or anyone close to you) felt you should cut down on:	Drinking?		
	Smoking?		
	Use of drugs?		
Have you ever used non-injecting drugs (marijuana, cocaine, crystal meth, Ritalin, Adderall, ecstasy)?			
Have you ever injected drugs, including steroids or hormones?			

Sexual History

Are you currently sexually active?	**Yes**	**No**	Number of current sexual partners?	Circle # of life time partners? **0-5** **More than 5**

Your sexual partners have been (check all that apply)	**Men**	**Women**	**Trans Men**	**Trans Women**

Do you have (check all that apply)?	Penis/Vagina Sex	Anal Sex	Oral Sex
Circle how often do you use safer sex methods (ie: condoms, dental dams, gloves, finger cots)?	Always	Usually	Sometimes / Never

	Yes	No		Yes	No
Do you feel safe and supported in your current relationship?			How old were you when you first had sex?		
Have you ever paid for sex?			Have you ever had sex while drunk or high?		
Have you ever traded sex for shelter, clothing, food, drugs, or money?			Have you ever had sex with someone who injects drugs?		

Have any of your past or current sexual partners been infected with an STI?	Yes	No	Current	Past	If so, which STI?

Do you have any specific sexual health questions you would like to address today?

Have you ever had?	Yes	No		Yes	No
Syphilis			Genital, Penile, Vulvar, Anal Warts		
HPV or abnormal pap smear			Gonorrhea		
Chlamydia			Herpes Oral/Genital		
HIV			Trichomonas		
Hepatitis A			Hepatitis B		
Hepatitis C			Pelvic Inflammatory Disease		
Vaginal Infections			Fibroids, cysts, tubal pregnancy		
Abnormal Pap Smear			Pain or bleeding with intercourse		
Mononucleosis			Rubella		
Chicken Pox			Cancer		
Do you perform breast or testicular self exams?			Do you have a history of fertility problems?		

Do you have any specific questions about STIs you would like to address today?

Menstrual History

	Yes	No		Yes	No
Date of your last period?			Was this period normal?		
Do you think you might be pregnant now?			Have you had sex without birth control since your last period?		
Age of your first period?			Are your periods: **REGULAR** **IRREGULAR**		
Are your periods: **LIGHT** **MODERATE** **HEAVY**			Have you ever missed periods?		
Do you ever have bleeding between periods?			Do you ever have pain with your periods?		
My period occurs every____ days.			Number of days of flow:_____		

Contraceptive History

Are you currently using birth control?	Yes	No	If yes, what one?

How long have you used this method?

List all methods you have used in the past:

Did you have any problems with these methods? If yes, please explain:

Pregnancy History

Number of pregnancies:	Number of full term births:	Number of premature births:
Number of abortions:	Number of miscarriages:	Number of living children:

I certify that I am voluntarily presenting myself for medical services and personal counseling provided by Highland Family Planning. I give permission to Highland Family Planning to use information contained in my medical record for statistical purposes with the understanding that confidentiality will be maintained.

PATIENT SIGNATURE_____ **DATE**_____