



PERSONAL HISTORY FORM

____ Provider Initials

Password _____

Assurances of Confidentiality: This medical record is confidential and will not be released to anyone without your written consent EXCEPT as may be required by law. All clients under the age of 18 are encouraged to talk with their parents about contraception and receiving services.

Name: _____ Birth Date: __/__/____ Age: _____

Marital Status _____

Are you able to read and understand English? ___ Yes ___ No

I am here today for: _____

Questions and Concerns I would like to discuss:

Do you have a doctor/clinic that you go to? ___Yes ___No

If "Yes": Name of Dr./Clinic _____ If "No": Referral _____

Please list any allergies to medications

Please list all medications you are taking (i.e. prescribed, over the counter, herbal):

List any hospitalizations, surgeries or serious illnesses:

Have you had a blood transfusion before 1984? ___No; If yes, when? _____

If you were born before 1971, could your mother have taken DES to prevent miscarriages? Yes
No

Please circle the following that you have been immunized for: Rubella (measles); Hepatitis B;
Gardasil (HPV)

How often do you exercise? _____ Use Alcohol? _____ Use Street Drugs? _____

Do you smoke? ___Yes ___No; If yes, what do you smoke and how many per day? _____

How long have you smoked? _____ Do you want to quit? ___Yes ___No



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Please check “yes” or “no” for the following questions about **YOUR** health history.

Yes	No	
		Systemic Lupus Erythematosus
		Emotional Problems/Depression
		Diabetes
		Chest Pain/Difficulty Breathing
		Seizures/Fainting/Neurological Disorders
		Heart Problems/Murmurs/High Blood Pressure
		High Cholesterol
		Blood Clots/Stroke/Varicose Veins
		Anemia/Blood Disorders
		Breast Disease/Lump/Nipple Discharge
		Stomach/Intestinal Problems
		Hepatitis/Liver Disease/Gall Bladder Disease
		Kidney or Bladder Problems
		Cancer
		Diagnosed Migraine Headaches with or without Aura (visual loss/disturbances)

Please check “yes” or “no” on the following questions about your **FAMILY** history.

Yes	No	
		Heart Disease or Death from Heart Attack before age 50 years
		High Blood Pressure
		Blood Clot/Stroke
		Diabetes
		Cancer
		High Cholesterol
		Genetic Disorders/Birth Defects



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Please answer the following questions regarding your sexual history.

Yes	No	
		At what age did you become sexually active? _____ years
		How many sexual partners have you had in the past year? ____ #
		Are you in a sexual relationship?
		How long have you been sexually active with your current partner?
		Do you use condoms?
		Has your partner had more than one partner in the past year?
		Have you or your partner had STD symptoms?
		Have you or your partner been to the STD clinic in the past year?
		Have you or your partner been treated for a STD in the past year?
		Have you or your partner been diagnosed with Gonorrhea/Syphilis/Chlamydia/Herpes/Warts/HIV
		Have you or your partner used drugs by needles?
		Have any of your partners been bisexual?
		Do you feel pressured to have sex?
		Has anyone touched you in a way that made you feel uncomfortable?
		Have you had sex when you didn't want to?
		Have you ever traded sex for money or drugs?
		Do you feel you need to have sex to feel loved?
		Has anyone ever hit or hurt you?
		Do you have sex with (please circle): Males Females Both
		Have you traveled to an area with Zika in the past 6-8 weeks?



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Please answer the following questions, if you are a female.

Age first period started? _____ First day of last menstrual period?

Any unusual/missed periods last year? ___ Yes ___ No

How many days do you bleed? _____; Is your bleeding: light medium heavy

Do you have severe cramps? Y N

When was your last pelvic exam? _____

Have you ever had an abnormal pap smear? Y N

Any unusual discharge, odor, itching, sores, rashes or bumps vaginally? Y N

Any pain or bleeding with sex? Y N;

Have you ever been diagnosed with Pelvic Inflammatory Disease? Y N

Have you ever been diagnosed with uterine growths, fibroids or abnormalities? Y N

How many times have you been pregnant? _____

How many miscarriages have you had? _____; How many abortions have you had? _____

Have you ever had an ectopic/tubal pregnancy? Y N

How many children do you have? _____;

Are you planning a pregnancy within the next year? Y N

Do you think you may be pregnant now? Y N

Please answer the following questions if you are a male.

Have you ever been treated for a urological condition? Y N

Have you ever had problems with reproductive functions? Y N

Contraceptive History

Are you currently using birth control? Y N; If yes, what method? _____

Are you currently having problems with your birth control? Y N; If yes, what problems?

What method of birth control would you like today? _____

To the best of my knowledge, the above information is complete and accurate.

Client Signature

Date

Reviewed By

Date