GENERAL HEALTH HISTORY

Instructions: Complete at initial visit and review at subsequent visits. **Date: ___ / ___ / ______**

SECTION 1. BASIC INFORMATION

1. Preferred Name: __________________________________

   Personal pronouns: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Other:____________

2. What is your gender? ☐Male ☐ Female ☐ Transgender Male (FtM) ☐ Transgender Female (MtF) ☐ Non-binary/Non-conforming ☐ Not Listed:__________________________

3. What sex were you assigned at birth? ☐ Male ☐ Female ☐ Intersex ☐ Not Listed:______________

4. Country of birth: ____________________ Primary language: ____________________

SECTION 2. MEDICAL HISTORY

- OFFICE USE ONLY - *Date and initial each entry*

Check below if you or any family member have the following:

	You	*Family*		*You*	*Family*
1. Allergies (food/insects/drugs/latex)			12. High blood pressure		
2. Anemia (low iron)			13. Intellectual disability or learning problem		
3. Asthma / respiratory problems					
4. Autoimmune disorder (lupus, rheumatoid arthritis, celiac, Crohn's, ulcerative colitis, etc.)			14. Kidney or bladder problems		
			15. Liver disease or hepatitis		
			16. Mental health issues (depression, anxiety, etc.)		
5. Blood clots (legs or lungs)					
6. Blood disease or bleeding problem			17. Migraines / headaches		
			18. Osteoporosis / osteopenia		
7. Cancer			19. Seizures / epilepsy		
a. Breast Cancer			20. Skin problems		
b. Ovarian Cancer			21. Sickle cell trait or disease		
c. Cervical Cancer			22. Stomach or bowel problems		
8. Diabetes (sugar)			23. Stroke		
9. G6PD deficiency			24. Thyroid problems		
10. Heart problems / murmurs			25. Tuberculosis or lung problem		
11. HIV / AIDS			26. Vision / eye problems		

27. Who is your primary/family doctor? ____ ☐ None

28. Have you ever been hospitalized? ☐ Yes ☐ No
   If yes, list dates and why:

29. Have you ever had surgery? ☐ Yes ☐ No
   If yes, list dates and why:

SECTION 3. INFECTION HISTORY

- OFFICE USE ONLY - *Date and initial each entry*

1. Have you ever been diagnosed with:	*Yes*	*No*		*Yes*	*No*
a. Gonorrhea			f. Trichomonas (trich)		
b. Chlamydia			g. Pelvic inflammatory disease (PID)		
c. Syphilis			h. Non-gonococcal urethritis (NGU)		
d. Herpes			i. Other/Unknown		
e. HPV/Genital warts					

	Yes	*No*
2. Did you receive a blood transfusion, blood products, or organ donation before 1992?		
3. Did you receive clotting factors prior to 1987?		

- OFFICE USE ONLY -

☐ *Interpreter or assistive services used* ☐ *Declined*

Name: ____

Title: _________________ Number: ____________

LABEL

Date: ___ / ___ / ______

SECTION 4. IMMUNIZATIONS & EXPOSURES	- OFFICE USE ONLY - *Date and initial each entry*
1. Have you been vaccinated for human papilloma virus (HPV), the virus that causes certain cancers and genital warts? ☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure 2. Have you been vaccinated for hepatitis B (HBV)? ☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure 3. Have you been vaccinated for hepatitis A (HAV)? ☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure 4. Check any of these substances that you now use, or have ever used: ☐ Cigarettes/tobacco/vaping How often? ___________ How much? __________ ☐ Alcohol/beer/wine/liquor How often? ___________ How much? __________ ☐ Marijuana How often? ___________ How much? __________ ☐ Crack/cocaine How often? ___________ How much? __________ ☐ Opioids (heroin/fentanyl/oxy) How often? ___________ How much? __________ ☐ Suboxone/methadone How often? ___________ How much? __________ ☐ Other: _______________ How often? ___________ How much? __________	

SECTION 5. BIRTH CONTROL (ALL CLIENTS)	- OFFICE USE ONLY - *Date and initial each entry*
1. Circle all birth control methods below that you or your partner have ever used: Condoms Foam Sponge Film Patch Ring IUD/IUS Cream Suppositories Diaphragm Cap Pill Shots (Depo-Provera) Implants Rhythm Withdrawal Cycle beads Emergency Contraception (Plan B) 2a. ***If you were assigned female at birth***, have you had your tubes tied, uterus removed, or Essure? ☐ Yes ☐ No 2b. ***If you were assigned male at birth***, have you had a vasectomy? ☐ Yes ☐ No 3. List any difficulties you experienced with prior birth control methods, if any:	

SECTION 6. IF ASSIGNED FEMALE AT BIRTH	- OFFICE USE ONLY - *Date and initial each entry*
1. At what age did your period start? _____________ 2. How often do you have a period? _________ How long do your periods last? __________ On your heaviest day, how many pads or tampons do you use per day? ___________ Do you ever miss a period? ☐ Yes ☐ No 3. Do you have period-related problems? (*i.e. cramps, abdominal swelling, mood swings*) ☐ Yes ☐ No 4. When was your last PAP smear or HPV test? ___________________ Where was it done? (name of office/facility) ____________________________________ 5. Have you ever had an abnormal PAP smear? ☐ Yes ☐ No ***If yes***, what kind of treatment did you receive? (check all that apply) ☐ Repeat PAP ☐ Colpo (date): _______ ☐ LEEP (date):_______ ☐ Don't know ☐ None	

LABEL

Date: ___ / ___ / ______

SECTION 7. HISTORY OF PREVIOUS PREGNANCIES (IF APPLICABLE)

Date	Weeks Carried	Pregnancy Result (circle one)	Type of Delivery (circle one)	Birth Weight	Place of Delivery	Complications
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			

Did you have either of the following during pregnancy?

Diabetes? ☐ Yes ☐ No

High blood pressure? ☐ Yes ☐ No

- OFFICE USE ONLY -

Additional Significant Findings:

- OFFICE USE ONLY -

REVIEW NOTES	*INITIALS*	*DATE*
☐ *Reviewed, initial visit*		
☐ *Reviewed, no changes* ☐ *Reviewed, changes as noted*		
☐ *Reviewed, no changes* ☐ *Reviewed, changes as noted*		
☐ *Reviewed, no changes* ☐ *Reviewed, changes as noted*		
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