Women's Health 2855 Valmont Road, Boulder, CO 80301 **&** 82 21st Avenue, Longmont, CO 80501

Today's Date: ____________ Name: (please print) ___________________________________ Date of Birth: ____________

2015 Health History

☐ I'm Adopted

	Me	My Biological Family	Explain who and/or when (ex: maternal grandma, sister, etc)
Birth Defects	☐	☐	______________________
Blood Clots in legs or lungs	☐	☐	______________________
Blood Problems (sickle cell anemia, bleeding disorder)	☐	☐	______________________
Breast disease	☐	☐	______________________
Cancer (specify type)	☐	☐	______________________
Colon or colorectal problems	☐	☐	______________________
Diabetes (type I, type II, or when pregnant)	☐	☐	______________________
Heart Disease (Stroke / Heart Attack)	☐	☐	______________________
High Blood Pressure (inc. during pregnancy)	☐	☐	______________________
High Cholesterol / Triglycerides	☐	☐	______________________
Liver / Kidney / Gall Bladder Issues	☐	☐	______________________
Mental Health Issues or depression	☐	☐	______________________
Osteoporosis	☐	☐	______________________
Thyroid Problems	☐	☐	______________________
Addiction (alcoholism, drugs)	☐	☐	______________________
Epilepsy	☐		______________________
Surgery – List dates & type	☐		______________________
Hernia	☐		______________________
Migraines (with numbness or visual changes)	☐		______________________
Frequent Bladder Infections or UTI	☐		______________________
Any history of STI? (genital herpes, genital warts, HIV, chlamydia, gonorrhea, syphilis, or PID)	☐		______________________
Abnormal Pap Test or HPV	☐	n/a ☐	______________________
Frequent vaginal infections (yeast or BV)	☐	n/a ☐	______________________
Ovary or Uterus problems	☐	n/a ☐	______________________

If you were born before 1970, did your mother take DES while pregnant? ☐ Yes ☐ No ☐ I Don't Know

Are you current on your vaccinations (shots), especially rubella? ☐ Yes ☐ No ☐ I Don't Know

Have you had the HPV vaccination (shot) also called Gardasil? ☐ Yes ☐ No ☐ I Don't Know

Please list all of your current medications, supplements or herbs: ____

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Please list any drugs or foods you are allergic to: ____

List any prescription drugs *not prescribed to you*, street drugs, or marijuana that you have used in the past year

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What kind of tobacco do you use? ☐ Smokeless/Chew ☐Daily____ ☐Weekly____ How many years? ____

☐ None ☐ Cigarettes/Cigars/Hookah/E-cigarettes ☐Daily____ ☐Weekly____ How many years? ____

How much alcohol (beer, wine, mixed drinks, shots) do you drink? ☐None _____drinks daily **or** _____drinks weekly

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When was the first day of your last period? ________________________ or ☐ I'm post-menopausal since _______

How old were you when your periods began? ______How often do you get your period? _________ How long does it last? ___ days

How heavy is the flow? ☐ Heavy ☐ Medium ☐ Light

Do you get cramps? ☐ No ☐ Yes Do you use pain medication for your cramps? ☐ No ☐ Yes, I use: ________________________

How many times have you been pregnant? ______

How many of your children are still living? ______

How old were you when your first child was born? ______

Are you breastfeeding now? ☐ No ☐ Yes

Have you had a baby that weighed less than 5 ½ pounds? ☐ No ☐ Yes

Have you had a baby that weighed more than 9 pounds? ☐ No ☐ Yes

Live births: ___ what year(s): _______________

Premature: ___ what year(s): _______________

C-Sections: ___ what year(s): _______________

Abortions: ___ what year(s): _______________

Miscarriages: ___ what year(s): _______________

Have you ever had sores on your penis or scrotum/testicles? ☐ Yes ☐ No ☐ n/a
Have you ever had abnormal discharge from your penis? ☐ Yes ☐ No ☐ n/a
Have you ever felt lumps in your scrotum/testicles? ☐ Yes ☐ No ☐ n/a

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The following questions are to help us take better care of you. Your honest answers will help us assess your risk factors for infections, medical problems and/or unintended pregnancy. This information is confidential. However, if you are under 18, we are required by law to report any case of sexual assault or abuse that has not already been reported.

How old were you when you started to be sexually active? _____
Have you ever been forced to have sex when you didn't want to? ☐ Yes ☐ No
Do you have a history of sexual assault or abuse? ☐ Yes ☐ No
Are you currently in a sexual relationship? ☐ Yes ☐ No
Is your primary sexual contact with someone who has a ☐ Penis ☐ Vagina ☐ _______________
How long have you been in your primary relationship? _____years, _____months
How many sexual partners have you had in the past 3 months who have a Penis_____ Vagina_____ ☐__________________
How many sexual partners have you had in the past year who have a Penis_____ Vagina_____ ☐__________________
What kind(s) of sex do you have? (circle all that apply) oral anal vaginal ☐__________________
Are you sexually active with anyone who has multiple partners? ☐ Yes ☐ No ☐ I Don't Know
Have any of your male partners ever had sex with other men? ☐ Yes ☐ No ☐ I Don't Know ☐ Not Applicable
Have you had sex in exchange for drugs, money, food or shelter in the past year? ☐ Yes ☐ No

Do you or your partner(s) have pain or bleeding with sex now? ☐ Yes ☐ No
Have you or your partner(s) ever used/shot IV drugs? ☐ Yes ☐ No ☐ I Don't Know
When was your last HIV test? __________
When was your last STI test? __________
Are you worried that you may have been exposed to HIV/AIDS? ☐ Yes ☐ No
Do you think that you may have an STI (infection) now? ☐ Yes ☐ No
What do you and your partner(s) do to protect yourself from sexually transmitted infections? ____

What do you do to prevent pregnancy? (check 1 or more) ☐ Not Applicable ☐ I want to be pregnant now ☐ Nothing
☐ Natural Family Planning ☐ Unsure ☐ Abstinence ☐ IUD
☐ Tubal Ligation / Tubes tied / Essure ☐ Vasectomy ☐ Shots (Depo) ☐ Implant
☐ Vaginal Ring (NuvaRing) ☐ Patch ☐ Withdrawal (pull-out) ☐ Spermicide
☐ External / roll-on / male condom ☐ Fem Cap or Diaphragm ☐ Pills
☐ Internal / female condom ☐ I rely on my partner's method: ________________________________

Do you have a history of mental, verbal or physical abuse? ☐ Yes ☐ No
Have you ever felt depressed or sought out counseling? ☐ Yes ☐ No

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How often do you eat **dairy foods** such as milk / cheese / yogurt / pudding / ice cream? Never 1/day 2/day 4-5/day 6-7/day
How often do you eat **grains** such as rice / pasta / bread / cereal? Never 1/day 2/day 4-5/day 6-7/day
How often do you eat **fruits and/or vegetables**? Never 1/day 2/day 4-5/day 6-7/day
How often do you eat **protein** such as eggs / beans / meat / tofu / fish / chicken? Never 1/day 2/day 4-5/day 6-7/day
How often do you **snack** on chips / salty food / cookies / cakes / candy / sugary food? Never 1/day 2/day 4-5/day 6-7/day
What do you **drink**? Mark how many per day:

Water ____ Regular soda ____ Diet Soda ____ Sports Drinks ____ Milk ____
Juice ____ Energy Drinks ____ Coffee/Tea ____ Flavored water ____

What type of exercise do you do? How often/how long? ____
Are you following a special diet? _________________ How many times a day do you eat? ______ meals/day ______ snacks/day
In a typical week, how many meals do you eat from a restaurant, including fast food? _____
How do you feel about your weight? ____
Are there any foods that you think that you don't eat enough of? ____

Is there anything else that we should know about you, your medical history or your sexual history that is important for your care?

Patient Signature: ___________________________ **Date:**______________ **Staff initials:** _____________ **Date:** __________