Medical History

Name ______________________________ Preferred Name ____________________________ Preferred pronouns (he/him, she/her, etc.) ________

Self-declared gender ❑ M ❑ F ❑ NA Are you transgender? ❑ Yes, MTF ❑ Yes, FTM ❑ Yes, Other ❑ No

What is the gender designation on your medical insurance records? ❑ M ❑ F

Reason for today's visit:____

The following information will help us provide you with the highest quality care.
Please fill out this health history as completely as possible. Thank you.

Medical History *Do you now have or have you had any of the following? Check all that apply.*

❑ Anemia/blood disorder
❑ Anesthesia Complications
❑ Blood transfusion
❑ Bleeding problems/blood disease
❑ Blood clots in veins
❑ Heart problems/surgery
❑ High blood pressure
❑ Stroke
❑ Severe varicose veins
❑ Rhogam injection/Rh negative
❑ Heart murmur
❑ Chest pain
❑ High cholesterol
❑ Nasal polyps
❑ Asthma/shortness of breath
❑ Bronchitis
❑ Sinusitis/allergies
❑ Frequent headaches
❑ Migraine headaches
❑ Muscle or nerve disease
❑ Blurred vision/blackouts
❑ Epilepsy/seizures
❑ Fainting
❑ Hepatitis/liver disease
❑ Gall bladder problems
❑ Kidney/bladder problems
❑ Thyroid disorder
❑ Hiatal hernia
❑ Ulcer
❑ Gastric Bypass surgery
❑ Bowel problems
❑ Breast problems
❑ Surgery on reproductive organs
❑ Sickle cell trait
❑ Cancer
❑ Diabetes
❑ Glaucoma/eye problems
❑ Rheumatic fever
❑ Tuberculosis
❑ Alcoholism
❑ Drug addiction
❑ Depression
❑ Suicidal thoughts/attempt
❑ Eating disorder
❑ Panic/anxiety disorder
❑ Have you ever been physically assaulted?
❑ Loose, false or chipped teeth
❑ Obstructive sleep apnea

Please list any allergies you have, and their reactions: ____

Are you currently taking any medications? Please list any prescriptions, supplements, vitamins or over-the-counter medications:

____

Do you have or have you had any medical problems? What are they? ____

Are you currently breastfeeding? ❑ yes ❑ no

Family History

Yes	No	Don't Know	*Is there a family history of any of the following? If so, please list which family member was affected.*
❑	❑	❑	Are you adopted?
❑	❑	❑	Anesthesia complication
❑	❑	❑	Heart disease
❑	❑	❑	Stroke
❑	❑	❑	Breast or reproductive system cancer
❑	❑	❑	Other cancer Explain: ________________________
❑	❑	❑	Lupus
❑	❑	❑	Arthritis
❑	❑	❑	Diabetes
❑	❑	❑	Kidney problems
❑	❑	❑	Osteoporosis (brittle bones)
❑	❑	❑	History of inheritable disease (Tay-Sachs, sickle cell anemia, etc.)

Self-identified Ethnicity or Race: ______________________
(we ask to be able to get grant funding from foundations)

Social History

Yes	No	
❑	❑	Do you exercise regularly? Type and amount per week: ________________________________
❑	❑	Do you use tobacco?
❑	❑	Do you smoke cigarettes? How many per day? _____ How many years have you smoked? _____
❑	❑	Were you previously a smoker?
❑	❑	Do you drink alcohol? How many drinks per week? _____
❑	❑	Do you use drugs for recreation? Please list: __________ ________________________ How often do you use? _____ times per day/week/month
❑	❑	Is vein access a problem for you?
❑	❑	Do you think you may have a problem with drugs or alcohol?

Would you like referrals or additional information for any of the following?

Yes	No		Yes	No	
❑	❑	Domestic violence	❑	❑	Emergency contraception
❑	❑	Rape/Sexual assault			
❑	❑	Physical abuse	❑	❑	Quitting smoking
❑	❑	Alcohol or drug dependency	❑	❑	Emotional problems

If you are here for a termination...

Do you feel that you have emotional support? ❑ yes ❑ no

How are you feeling about your decision to have an abortion?

❑ Very sure ❑ Sure ❑ Unsure

CEDAR RIVER CLINICS

❑ **Renton** ❑ **Tacoma** ☐ **Seattle**

Current Symptoms

Are you currently experiencing any of the following? How long? Check all that apply.

- ❑ Abdominal pain
- ❑ Lower backache
- ❑ Genital burning
- ❑ Genital itching
- ❑ Unusual discharge
- ❑ Irregular bleeding
- ❑ Pain during or after intercourse
- ❑ Bleeding after intercourse
- ❑ Pain during or after orgasm
- ❑ Rash/bumps/sores in genital area
- ❑ Fever
- ❑ Pain/burning with urination
- ❑ Frequent urination
- ❑ Small amounts of urine
- ❑ Bloody urine
- ❑ Has your sexual partner had any of the symptoms listed above? Which ones? ______________________

______________________ How long?__________

Reproductive Health History

Do you have or have you had any of the following? Check all that apply.

- ❑ Abnormal Pap smear result
- ❑ Biopsy/colposcopy
- ❑ Laparoscopy/laparotomy
- ❑ Cervical/uterine cancer
- ❑ Cancer: __________
- ❑ Endometriosis
- ❑ Endometritis (infection of the uterus)
- ❑ Vaginal infection
- ❑ Abnormal uterus shape/position
- ❑ Fibroids
- ❑ Pelvic Inflammatory Disease (PID)
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ HPV/genital warts
- ❑ Herpes
- ❑ Syphilis
- ❑ Bacterial vaginosis (BV)
- ❑ Breast lump/cancer
- ❑ Infertility problems
- ❑ Urinary tract infection (UTI)
- ❑ Pre-eclampsia/toxemia
- ❑ Excessive bleeding
- ❑ Date of last Pap smear: ________
- ❑ Have you had the HPV vaccine? How many doses? _____
- ❑ Other______________________

Pregnancy History ❑ not applicable

Please list the total number of:

If pregnant, is this your first pregnancy? ❑ yes ❑ no	Pregnancies	Births	Premature Deliveries	Abortions	Miscarriages	Living Children	Cesarean sections	Ectopic	Genetic Defects	

Please explain any pregnancy complication:

Menstrual History ❑ not applicable

Age at first period: ______

Date last period began: __________

Was it a normal period? ❑ yes ❑ no If not, please explain:

____

____

Your periods are: ❑ regular ❑ irregular ❑ absent ❑ painful

Your periods come about every _____ weeks for _____ days.

On heavy days, number of pads/tampons used daily: _______

Any recent changes in your menstrual pattern? ❑ yes ❑ no

If so, what changes? ______________________

____

____

Contraceptive History

What, if any, form of birth control are you currently using?

____

Any problems with it? ______________________

Do you want to change your method of birth control? If so, which method(s) are you interested in? ______________________

Have you used any of these contraceptives in the past?

❑ The Pill ❑ Depo Provera ❑ IUD ❑ Male Condom

❑ Female Condom ❑ Foam/Jelly ❑ Sponge ❑ Cervical cap

❑ Diaphragm ❑ Rhythm/Fertility Awareness Method

❑ ECT/Emergency Contraceptive ❑ The Patch ❑ Vaginal Ring

❑ Withdrawal

Any problems with them? ______________________

Do you want children in the future? ❑ yes ❑ no ❑ unsure

Client Signature	**Date**
Interpreter Signature	**Date**
Interpreter Agency	

Sexual History / Orientation

At what age did you first have sexual intercourse? __________

Are you currently having sex? ❑ yes ❑ no

Check all that apply: ❑ vaginal ❑ oral ❑ anal

Are your sexual partners ❑ male ❑ female ❑ both

How many partners have you had in the past 60 days? ______

Has your partner been sexual with anyone else in the last 12 months?

❑Yes ❑Not Sure ❑No

Yes	***No***	*Have you...?*
❑	❑	Had a new sex partner in the last 60 days?
❑	❑	Used a condom the last time you had intercourse?