COBB & DOUGLAS PUBLIC HEALTH

Name:

Computer Number:

DOB:

MEDICAL HISTORY FORM

Main reason for today's visit: _____

MEDICATIONS: Please list all prescriptions and non-prescription medications (including birth control, over the counter meds, herbs, etc.):_____

ALLERGIES or intolerance to medications? □ Yes □ NONE

(If yes, to what & what reaction? ___

Your Preferred name:	What sex was originally listed on your birth certificate? □ Male □Female
Sexual Orientation	Do you think of yourself as: □ Straight/Heterosexual □ Gay □ Bisexual □Lesbian □Pansexual □Asexual □Questioning □ Prefer Not to Answer □ Other (please describe):
Gender Identity	Do you think of yourself as: □ Male □ Female □ Transgender Man □Transgender Woman □ Non-Binary □Genderqueer □ Other (please describe):

_____

SOCIAL HISTORY

Exercise:	Do you exercise regularly? □ Yes □ No
Alcohol Use:	Do you drink alcohol? □ Yes □ No □ Beer □ Wine □Liquor # of Drinks per week: _____ How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? □ 0 DAYS □ 1 or More than 1 Day
Tobacco Use:	□ Current □ Never □ Former: quit on: _____ *If current # of packs/day ___ # of years ____ **Other Tobacco** □ Pipe □ Cigar □Snuff □Chew
Do you use e-cigarettes	□ No □ Used in the Past □Not Presently □ Occasionally □ Daily
Drug Use:	Do you use recreational drugs? □ Never □ Rarely □Often _____# times per month If yes, If yes, What Drugs?_____ If you have used in the past, how long have you been drug free? _____ Does your partner use recreational drugs? □ Yes □ No What drug(s)? _____ How often? _____
Safety	Are you currently or have you ever been in a relationship where you are physically hurt, threatened, or made to feel afraid? □ Yes □ No Do you feel safe in your current relationship? □ Yes □ No
Emotions	Over the **last 2 weeks**, how often have you been bothered by the following problems?

1.Little interest or pleasure in doing things.	□ Not at all	□ Several days	□ More than Half the Days	□ Nearly Every Day
2. Feeling down, depressed, or hopeless	□ Not at all	□ Several days	□ More than Half the Days	□ Nearly Every Day

SEXUAL HISTORY

When was your last sexual encounter?

Sex of your Partners: □ Male □ Female □ Both

How many partners have you had in the last 3 months? _____ Of those, how many were new partners? _____

How many sexual partners have you had in the last year?

Do you perform oral sex? □ Yes □ No Do you receive anal sex? □ Yes □ No

Do you use condoms? □ Always □ Sometimes □ Never

Are any of your sexual partners currently having symptoms or being treated for STI? □ Yes □ No

If yes, please explain: _____

Have you, or any of your partners, ever exchanged money or drugs for sex? □ Yes □ No

Have you ever been tested for HIV? □ Yes □ No If yes, when: _____Result (circle): Negative or Positive

PLEASE INDICATE WHETHER YOU HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

PERSONAL MEDICAL HISTORY			If yes, please give date and explain
SEVERE HEADACHE	❑ YES	❑ NO	
HIGH BLOOD PRESSURE	❑ YES	❑ NO	
THYROID DISEASE	❑ YES	❑ NO	
DIABETES	❑ YES	❑ NO	
BLOOD CLOTS IN LUNGS OR LEGS	❑ YES	❑ NO	
STROKE	❑ YES	❑ NO	
HEART DISEASE OR MURMUR	❑ YES	❑ NO	
SEIZURES	❑ YES	❑ NO	
DEPRESSION /ANXIETY/ BIPOLAR DISORDER	❑ YES	❑ NO	
HEPATITIS OR LIVER DISEASE	❑ YES	❑ NO	
TUBERCULOSIS	❑ YES	❑ NO	
SEXUALLY TRANSMITED INFECTION	❑ YES	❑ NO	
TUBAL OR ECTOPIC PREGNANCY	❑ YES	❑ NO	
BREAST PROBLEM	❑ YES	❑ NO	
KIDNEY DISEASE	❑ YES	❑ NO	
CANCER	❑ YES	❑ NO	
UNEXPLAINED VAGINAL BLEEDING	❑ YES	❑ NO	
HOSPITALIZATION OR SURGERIES	❑ YES	❑ NO	
OTHER	❑ YES	❑ NO	

FOR FEMALE PATIENTS ONLY

What was the FIRST day of your LAST period? _____ Period Duration: _____ days
Period pattern: □ Regular □ Irregular Menstrual Flow: □ Light □ Moderate □ Heavy

Birth control method (check all that apply): □ None □ Condom □ Pill □ IUD □ Patch □ Implant □ Ring □ Diaphragm □ Vasectomy □ Tubal ligation □ Other method_____

Date of your last pregnancy/miscarriage/or abortion: _____ Total # Pregnancies: _____

Total # Premature Births: _____ Total # Abortions/Miscarriages: _____ Total # Living Children: _____

Do you believe you may be pregnant now? □Yes □No □Maybe

If not, are you currently trying to get pregnant? □ YES □ NO

Are you currently breastfeeding? □YES □ NO If yes, how often per day? _____

Are you currently having breast problems? □YES □ NO Please explain: _____

Have you ever had an abnormal Pap Test? □YES □ NO

Do you douche? YES/NO If yes, how often? _____

Have you ever had a hysterectomy or tubal ligation? □YES □NO If yes, year: _____

Age of Menopause onset: _____ Have you had post-menopausal spotting/bleeding? □ YES □ NO

Patient Signature _____ Date_____

Provider Signature_____Date_____