

Patient Name _____ Pronoun _____ Age _____

HISTORY Date _____ Do you have or have you ever had the following?:

	YES	NO		YES	NO		YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Genital Warts	<input type="checkbox"/>	<input type="checkbox"/>	Liver Condition	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Bleeding Disorder/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches with Aura	<input type="checkbox"/>	<input type="checkbox"/>
Cancer			Gonorrhea/Syphilis/Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease-AHA Class 3 or higher	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cone Biopsy/LEEP	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type A B C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cryotherapy	<input type="checkbox"/>	<input type="checkbox"/>	IUD in place	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Last Seizure _____	<input type="checkbox"/>	<input type="checkbox"/>	Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Systematic Lupus Erythematosus	<input type="checkbox"/>	<input type="checkbox"/>
Fibroid Uterus	<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>

Do you have asthma? Y N If yes, most recent hospital visit _____

Did you bring your inhaler? Y N

Explanation of above or other problems not listed: _____

When was your last normal period? _____ How far along in the pregnancy do you think you are? _____

Number of births _____ Miscarriage(s) _____ Ectopic(s) _____ Abortion(s) _____ (_____)

Vaginal deliveries _____ # C-Sections _____ Have you ever been told you always have to have a C-section? Y N

Any Problems? Y/N If yes please explain _____

SOCIAL BEHAVIORS

Marijuana use Y N Recreation drug use Y N Type of drug(s) _____ Dependence Y N

Prescription pain medication abuse Y N Type of medication _____ Last taken _____

Alcohol use Y N Socially / Moderately / Dependent Do you smoke anything Y N What? _____ Amount _____

HOSPITAL/SURGERY

Any surgery on cervix? _____ Other surgeries(type: dates) _____

History of ectopic pregnancy Y N if yes, treatment with surgery / medication (circle)

Hospitalizations Y N Details _____

Have you had a C-section? Y N At what length of pregnancy? _____ Have you ever been told you always have to have a C-section? Y N

Have you ever been told by a physician that your uterus or reproductive organs are abnormal? (i.e. bicornate uterus) _____

MEDICATION

Are you currently under a doctor's care? Y N Reason _____

Current medication(s) _____

For _____

Any medication or drugs taken in the past 24 hours _____

Allergies and/or reactions to drugs, medication, or sedation/analgesia or anesthetic technique? Y N Type of reaction _____

Skin reactions to Betadine/Iodine Y N _____

When is the last time you had something to eat or drink? _____

Are you taking any herbal supplements? Y N _____

MENTAL HEALTH

Treatment for mental illness- including depression, bi-polar, mood disorders, anxiety Y N Details _____

Psychiatric, psychological or social work evaluation or treatment Y N Details _____

Anger management issues Y N Details _____

MISCELLANEOUS

Do you have an advanced directive? ___ Yes ___ No If yes, please specify _____

In regard to the above check list, do any of these apply to your immediate family (mother, father, brother, sister) _____

List previous birth control methods used _____ Type(s) interested in for the immediate future _____

Did you become pregnant while using birth control? Y N If yes, what type and brand name? _____

I have completed the History Section and it is accurate to the best of my knowledge.

(Patient Signature)

Staff Signature

Rtn date

Staff Signature