Please list any questions, concerns, or changes in your health you want to discuss:

- Are you experiencing any of the following symptoms today? Circle all that apply:
  - Bleeding/Pain with Sex
  - Bumps/Sores/Blisters
  - Pain with Urination
  - Frequent Urination
  - Itching
  - Tender Testicles
  - Abdominal Pain
  - Unusual Discharge
  - Unusual Smell
  - Other
- Have you ever been tested for HIV? No Yes Would you like to be tested for HIV? No Yes

PLEASE ANSWER THESE QUESTIONS IF THEY APPLY TO YOU

- Have you ever had a serious illness, migraine headache, or blood clots? If so, which? __________________________
- With headaches, have you ever had loss of your vision, slurred speech, or numbness or tingling in your arms or legs? __________
- How often do you get your period? (How many days between the first day of two periods)? __________________________
- Would you consider your period abnormal? If yes, how would you describe it? __________________________
- List any symptoms you get before or during your period? __________________________
- Have you ever had a pelvic exam or pap smear? If so, have you ever had an abnormal pap result? Yes No
- Have you ever been offered food, money, or other things in exchange for sex/sexual contact? __________________________
- What forms of birth control have you used?
  - Condoms
  - Depo
  - Pills
  - NuvaRing
  - Patch
  - IUD
  - Diaphragm
  - Spermicide
  - Rhythm
  - Withdrawal
  - Implanon
- In the past year have there been any significant changes in your family, friends or living situation? Need to improve a little Need to improve a lot
- With headaches, have you ever had loss of your vision, slurred speech, or numbness or tingling in your arms or legs? __________________________
- Are you a vegetarian? __________________________
- Have you ever had a pelvic exam or pap smear? Yes No
- Would you consider your period abnormal? If yes, how would you describe it? __________________________
- How many days a week do you eat take-out or fast food? ______________
- How would you rate your eating behaviors? Good Need to improve a little
- How often do you get your period? (How many days between the first day of two periods)? __________________________
- List any symptoms you get before or during your period? __________________________
- Have you ever been offered food, money, or other things in exchange for sex/sexual contact? __________________________
- Have you ever been tested for HIV? No Yes Would you like to be tested for HIV? No Yes
- Have you ever had a pelvic exam or pap smear? Yes No
- Would you consider your period abnormal? If yes, how would you describe it? __________________________
- How many people have you had sexual contact with in the past 6 months? _______ Past 12 months? _______ Ever? _______
- Which forms of sexual contact have you had: None Vaginal Oral (mouth) Anal (buttocks)
- How many days a week do you eat take-out or fast food? ______________
- How would you rate your eating behaviors? Good Need to improve a little
- How often do you get your period? (How many days between the first day of two periods)? __________________________
- List any symptoms you get before or during your period? __________________________
- Have you ever been offered food, money, or other things in exchange for sex/sexual contact? __________________________
- Have you ever been tested for HIV? No Yes Would you like to be tested for HIV? No Yes
- Have you ever had a pelvic exam or pap smear? Yes No
- Would you consider your period abnormal? If yes, how would you describe it? __________________________
- How many days a week do you eat take-out or fast food? ______________
- How would you rate your eating behaviors? Good Need to improve a little
- How often do you get your period? (How many days between the first day of two periods)? __________________________
- List any symptoms you get before or during your period? __________________________
- Have you ever been offered food, money, or other things in exchange for sex/sexual contact? __________________________
- Have you ever been tested for HIV? No Yes Would you like to be tested for HIV? No Yes

Give an example of something that you are proud of about yourself. __________________________________________

Reviewed by ____________________ MD NP RN ___________________________ Date
Health History

Enter Data From This Side Only

Have you ever had:
- Blood Clots (legs, lungs, blood vessels, etc.)
- Breast or Other Reproductive Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Liver Disease
- Mental Health Diagnosis (Depression, etc.)
- Stroke

Have any biological family members ever had:
- Blood Clots (legs, lungs, blood vessels, etc.)
- Breast or Other Reproductive Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Liver Disease
- Mental Health Diagnosis (Depression, etc.)
- Stroke

I don't know

I'm adopted and don't know

How often have you been bothered by each of the following symptoms during the past two weeks?
0 = not at all; 1 = several days; 2 = more than half the days; 3 = nearly everyday

Circle the number that best applies:

1. Little interest or pleasure in doing things?
2. Feeling down, depressed or hopeless?
3. Trouble falling asleep, staying asleep or sleeping too much?
4. Feeling tired or having little energy?
5. Poor appetite, weight loss or overeating?
6. Feeling bad about yourself or feeling that you're a failure or that you have let yourself or your family down?
7. Trouble concentrating on things like school work, reading or watching TV?
8. Moving or speaking so slowly that other people could have noticed or, the opposite, being so fidgety or restless that you were moving around a lot more than usual?
9. Thoughts that you would be better off dead or of hurting yourself in some way?
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Circle one:
- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

No Yes
11. Do you have difficulty controlling worry or anxious feelings?
No Yes
12. In the past year, have you felt depressed or sad most days even if you felt OK sometimes?
No Yes
13. Has there been a time in the past month when you have had serious thoughts about ending your life?
No Yes
14. Do you have access to any weapons?
No Yes
15. Is anyone hurting you or threatening you? This includes being bullied.
No Yes
16. Do you have a trusted person you can talk with freely?
No Yes
- Is your partner kind to you and respectful of your choices?
No Yes
- Does your partner ever mess with your birth control or try to get you pregnant?
No Yes
- Do you smoke cigarettes or use any other form of tobacco? If yes, how much each day? _______
   How many years have you smoked? ______
No Yes
- Do you live with or hang out with people that smoke?
No Yes
- In the past year, have you used alcohol? If yes, what do you drink? ______ How many drinks do you typically have? ______
No Yes
- In the past year, have you smoked marijuana orhashish? If yes, how often do you use it? __________________
No Yes
- In the past year have you used anything else to get high (i.e. illegal drugs, over-the-counter or prescription meds)?
   If yes, what have you used and how often? ____________________________

Reviewed by ___________________                     MD     NP    RN                           _______________________________ Date