Health History Label

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

No Yes • *Have you ever had a serious illness, migraine headache or blood clots? If so, which?* _____
No Yes • 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)? _____
No Yes • Would you consider your period abnormal? If yes, how would you describe it? _____
• List any symptoms you get before or during your period? _____
No Yes • Have you ever had a pelvic exam or pap smear? If so, have you ever had an abnormal pap result? Yes No
No Yes • Have you ever been pregnant? If so, # of children ____ # of abortions _____ # of miscarriages ____ # of adoptions _____

• If you are currently on the pill, the patch or the NuvaRing, list any side effects you are concerned about:
_____
If you are currently on the pill, the patch, the NuvaRing or Depo, IN THE PAST MONTH have you:

No	Yes	Missed any pills by 6 hours or more?	Not using pills
No	Yes	Missed any patches by 48 hours or more?	Not using patch
No	Yes	Missed taking out or putting in a new ring?	Not using NuvaRing
No	Yes	Missed getting a Depo shot on time?	Not using Depo

• If you did miss/were late for a pill, patch, Depo shot or NuvaRing, what did you do to keep from getting pregnant?
Circle all that apply: Didn't change my behavior Didn't have sex Condoms Spermicide Morning after pill

No Yes • Do you have concerns about your chemical use, or have you been criticized for your chemuical use?
No Yes • Have you ever ridden in a car driven by someone (including yourself) who had been using drugs or alcohol?
• Do you identify as: Male Female Transgender Other: _____
• Are you attracted to: Men Women Both Other
No Yes • Are you sexually active? With whom? Men Women Both Other
Which forms of sexual contact have you had: None Vaginal Oral (mouth) Anal (buttocks)
• How many people have you had sexual contact with in the past 6 months? _____ Past 12 months? _____ Ever? _____
No Yes • Have you ever been a victim of sexual abuse or assault or has anyone touched you sexually that you didn't want?
No Yes • Have you ever been offered food, money or other things in exchange for sex/sexual contact?
No Yes • What forms of birth control have you used? *Circle all that apply:*
Condoms Depo Pills NuvaRing Patch IUD Diaphgram Spermicide Rhythm Withdrawal Implanon
Circle the % of times you use condoms: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Yes • Have you ever been diagnosed with a sexually transmitted infection/disease? Chlamydia Gonorrhea Other _____
If yes, did you take all of your medication? Yes No Was your partner treated? Yes No
No Yes • Are you in school? If so, what grade? _____ If no, how do you spend your day? _____
No Yes • Do you work? If yes, how many hours per week? _____
No Yes • Do you feel safe where you live? Where do you live? _____
• How would you rate your eating behaviors? *Circle one:*
Good Need to improve a little Need to improve a lot
• How many glasses of water do you drink each day? _____
No Yes • Are you a vegetarian?
• How many days a week to you eat take out or fast food? _____
No Yes • Do you take vitamins or supplements?
• How many days a week do you exercise?_____ What do you do for exercise? _____
No Yes • Do you have any concerns about your body size and/or type?
No Yes • Do you spend more than two hours per day watching TV, movies, or playing computer games?
No Yes • Do you have trouble getting enough food to eat?
No Yes • Have you been to a dentist in the last 12 months?
No Yes • In the past year have there been any significant changes in your family, friends or living situation?
No Yes • Do you feel you have a significant amount of stress in your life? If yes, what is the cause? Circle all that apply:
No Yes School Relationships Parents Work Money Lack of Sleep Other: _____
Give an example of something that you are proud of about yourself. _____

Reviewed by _____ MD NP RN _____ Date

Health History Label

Enter Data From This Side Only

Have you ever had:			If yes, who? What age?
• Blood Clots (legs, lungs, blood vessels, etc.)	No	Yes	
• Breast or Other Reproductive Cancer	No	Yes	
• Diabetes	No	Yes	
• Heart Disease	No	Yes	
• High Blood Pressure	No	Yes	
• High Cholesterol	No	Yes	
• Liver Disease	No	Yes	
• Mental Health Diagnosis (Depression, etc.)	No	Yes	
• Stroke	No	Yes	

☐ ***I don't know***

Have any **biological family members** ever had:		
• Blood Clots (legs, lungs, blood vessels, etc.)	No	Yes
• Breast or Other Reproductive Cancer	No	Yes
• Diabetes	No	Yes
• Heart Disease	No	Yes
• High Blood Pressure	No	Yes
• High Cholesterol	No	Yes
• Liver Disease	No	Yes
• Mental Health Diagnosis (Depression, etc.)	No	Yes
• Stroke	No	Yes

☐ ***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?	0 1 2 3
2. Feeling down, depressed or hopeless?	0 1 2 3
3. Trouble falling asleep, staying asleep or sleeping too much?	0 1 2 3
4. Feeling tired or having little energy?	0 1 2 3
5. Poor appetite, weight loss or overeating?	0 1 2 3
6. Feeling bad about yourself or feeling that you're a failure or that you have let yourself or your family down?	0 1 2 3
7. Trouble concentrating on things like school work, reading or watching TV?	0 1 2 3
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?	0 1 2 3
9. Thoughts that you would be better off dead or of hurting yourself in some way?	0 1 2 3

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 or hashish? 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