Saginaw County
HEALTH DEPARTMENT

____Provider Initials **Personal History** **Password**_____

Assurances of Confidentiality: This medical record is confidential and will not be released to anyone without your written consent EXCEPT as may be required by law. All clients under the age of 18 are encouraged to talk with their parents about contraception and receiving services.

Name: _____ Birth Date: __/__/____ Age: _____

Check one: Single ___ Married ___ Divorced ___ Separated ___

Are you able to read and understand English? ___ Yes ___ No

I am here today for: _____

Questions and Concerns I would like to discuss:
_____
_____

Do you have a doctor/clinic that you go to? ___Yes ___No

If "Yes": Name of Dr./Clinic _____ If "No": Referral _____

Please list any allergies to medications:
_____
_____

Please list all medications you are taking (i.e. prescribed, over the counter, herbal):
_____
_____

List any hospitalizations, surgeries or serious illnesses:
_____
_____

Have you had a blood transfusion before 1984? ___ No; If yes, when? _____

If you were born before 1971, could your mother have taken DES to prevent miscarriages?
Yes No

Please circle the following that you have been immunized for: Rubella (measles); Hepatitis B; Gardasil (HPV)

How often do you exercise? _____ Use Alcohol? _____ Use Street Drugs? _____

Do you smoke? ___Yes ___No; If yes, what do you smoke and how many per day?
_____

How long have you smoked? _____ Do you want to quit? __Yes __No

Please check “yes” or “no” for the following questions about **YOUR** health history.

Yes	No	
		Systemic Lupus Erythematous
		Emotional Problems/Depression
		Diabetes
		Chest Pain/Difficulty Breathing
		Seizures/Fainting/Neurological Disorders
		Heart Problems/Murmurs/High Blood Pressure
		High Cholesterol
		Blood Clots/Stroke/Varicose Veins
		Anemia/Blood Disorders or Diseases
		Breast Disease/Lump/Nipple Discharge
		Stomach/Intestinal Problems
		Hepatitis/Liver Disease/Gall Bladder Disease
		Kidney or Bladder Problems
		Cancer
		Diagnosed Migraine Headaches with or without Aura (visual loss/disturbances)

Please check “yes” or “no” on the following questions about your **FAMILY** history.

Yes	No	
		Heart Disease or Death from Heart Attack before age 50 years
		High Blood Pressure
		Blood Clot/Stroke
		Diabetes
		Cancer
		High Cholesterol
		Genetic Disorders/Birth Defects

Please answer the following questions regarding your sexual history.

Yes	No	
		At what age did you become sexually active? _____years
		How many sexual partners have you had in the past year? ____#
		Are you in a sexual relationship?
		How long have you been sexually active with your current partner?
		Do you use condoms?
		Has your partner had more than one partner in the past year?
		Have you or your partner had STD symptoms?
		Have you or your partner been to the STD clinic in the past year?
		Have you or your partner been treated for a STD in the past year?
		Have you or your partner been diagnosed with Gonorrhea/ Syphilis/ Chlamydia/ Herpes/ Warts/ HIV?
		Have you or your partner used drugs by needles?
		Have any of your partners been bisexual?
		Do you feel pressured to have sex?
		Has anyone touched you in a way that made you feel uncomfortable?
		Have you had sex when you didn't want to?
		Have you ever traded sex for money or drugs?
		Do you feel you need to have sex to feel loved?
		Has anyone ever hit or hurt you?
		Do you have sex with (please circle): Males Females Both
		Have you traveled to an area with Zika in the past 6-8 weeks?

Please answer the following questions, if you are a female.

Age first period started? _____
First day of last menstrual period? _____
Any unusual/missed periods last year? ___Yes ___No
How many days do you bleed? _____; Is your bleeding: light medium heavy
Do you have severe cramps? Y N

When was your last pelvic exam? _____
Have you ever had an abnormal pap smear? Y N
Any unusual discharge, odor, itching, sores, rashes or bumps vaginally? Y N
Any pain or bleeding with sex? Y N;
Have you ever been diagnosed with Pelvic Inflammatory Disease? Y N
Have you ever been diagnosed with uterine growths, fibroids or abnormalities? Y N
How many times have you been pregnant? _____
How many miscarriages have you had? ____; How many abortions have you had? ___
Have you ever had an ectopic/tubal pregnancy? Y N
How many children do you have? ____
Are you planning a pregnancy within the next year? Y N
Do you think you may be pregnant now? Y N

Please answer the following questions if you are a male.

Have you ever been treated for a urological condition? Y N
Have you ever had problems with reproductive functions? Y N

Contraceptive History

Are you currently using birth control? Y N; If yes, what method? _____
Are you currently having problems with your birth control? Y N; If yes, what problems?
_____

What method of birth control would you like today? _____

To the best of my knowledge, the above information is complete and accurate.

_____ _____
Client Signature Date

_____ _____
Reviewed By Date

8/16; Rev. 10/16, 3/19, 6/19