GENERAL HEALTH HISTORY

Instructions: Complete at initial visit and review at subsequent visits. **Date:** ___ / ___ / _____

SECTION 1. BASIC INFORMATION

1. Preferred Name: _____

   Personal pronouns: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Other:_____

2. What is your gender? ☐Male ☐ Female ☐ Transgender Male (FtM) ☐ Transgender Female (MtF)
   ☐ Non-binary/Non-conforming ☐ Not Listed:_____

3. What sex were you assigned at birth? ☐ Male ☐ Female ☐ Intersex ☐ Not Listed:_____

4. Country of birth: _____ Primary language: _____

SECTION 2. MEDICAL HISTORY

- OFFICE USE ONLY -

Date and initial each entry

Check below if you or any family member have the following:

	You	*Family*		*You*	*Family*
1. Allergies (food/insects/drugs/latex)			12. High blood pressure		
2. Anemia (low iron)			13. Intellectual disability or learning problem		
3. Asthma / respiratory problems					
4. Autoimmune disorder (lupus, rheumatoid arthritis, celiac, Crohn's, ulcerative colitis, etc.)			14. Kidney or bladder problems		
			15. Liver disease or hepatitis		
			16. Mental health issues (depression, anxiety, etc.)		
5. Blood clots (legs or lungs)					
6. Blood disease or bleeding problem			17. Migraines / headaches		
			18. Osteoporosis / osteopenia		
7. Cancer			19. Seizures / epilepsy		
a. Breast Cancer			20. Skin problems		
b. Ovarian Cancer			21. Sickle cell trait or disease		
c. Cervical Cancer			22. Stomach or bowel problems		
8. Diabetes (sugar)			23. Stroke		
9. G6PD deficiency			24. Thyroid problems		
10. Heart problems / murmurs			25. Tuberculosis or lung problem		
11. HIV / AIDS			26. Vision / eye problems		

27. Who is your primary/family doctor? _____ ☐ None

28. Have you ever been hospitalized? ☐ Yes ☐ No
If yes, list dates and why:

29. Have you ever had surgery? ☐ Yes ☐ No
If yes, list dates and why:

SECTION 3. INFECTION HISTORY

- OFFICE USE ONLY -

Date and initial each entry

1. Have you ever been diagnosed with:	*Yes*	*No*		*Yes*	*No*
a. Gonorrhea			f. Trichomonas (trich)		
b. Chlamydia			g. Pelvic inflammatory disease (PID)		
c. Syphilis			h. Non-gonococcal urethritis (NGU)		
d. Herpes			i. Other/Unknown		
e. HPV/Genital warts					
2. Did you receive a blood transfusion, blood products, or organ donation before 1992?					
3. Did you receive clotting factors prior to 1987?					

- OFFICE USE ONLY -

☐ *Interpreter or assistive services used* ☐ *Declined*

Name: _____

Title: _____ Number: _____

LABEL

Date: ___ / ___ / _____

SECTION 4. IMMUNIZATIONS & EXPOSURES

- OFFICE USE ONLY -

Date and initial each entry

1. Have you been vaccinated for human papilloma virus (HPV), the virus that causes certain cancers and genital warts?
   ☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure
2. Have you been vaccinated for hepatitis B (HBV)?
   ☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure
3. Have you been vaccinated for hepatitis A (HAV)?
   ☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure
4. Check any of these substances that you now use, or have ever used:

☐ Cigarettes/tobacco/vaping	How often? _____	How much? _____
☐ Alcohol/beer/wine/liquor	How often? _____	How much? _____
☐ Marijuana	How often? _____	How much? _____
☐ Crack/cocaine	How often? _____	How much? _____
☐ Opioids (heroin/fentanyl/oxy)	How often? _____	How much? _____
☐ Suboxone/methadone	How often? _____	How much? _____
☐ Other: _____	How often? _____	How much? _____

SECTION 5. BIRTH CONTROL (ALL CLIENTS)

- OFFICE USE ONLY -

Date and initial each entry

1. Circle all birth control methods below that you or your partner have ever used:
   Condoms Foam Sponge Film Patch Ring IUD/IUS Cream
   Suppositories Diaphragm Cap Pill Shots (Depo-Provera) Implants
   Rhythm Withdrawal Cycle beads Emergency Contraception (Plan B)
2a. ***If you were assigned female at birth***, have you had your tubes tied, uterus removed, or Essure? ☐ Yes ☐ No
2b. ***If you were assigned male at birth***, have you had a vasectomy? ☐ Yes ☐ No
3. List any difficulties you experienced with prior birth control methods, if any:

SECTION 6. IF ASSIGNED FEMALE AT BIRTH

- OFFICE USE ONLY -

Date and initial each entry

1. At what age did your period start? _____
2. How often do you have a period? _____ How long do your periods last? _____
   On your heaviest day, how many pads or tampons do you use per day? _____
   Do you ever miss a period? ☐ Yes ☐ No
3. Do you have period-related problems? (*i.e. cramps, abdominal swelling, mood swings*) ☐ Yes ☐ No
4. When was your last PAP smear or HPV test? _____
   Where was it done? (name of office/facility) _____
5. Have you ever had an abnormal PAP smear? ☐ Yes ☐ No
   If yes, what kind of treatment did you receive? (check all that apply)
   ☐ Repeat PAP ☐ Colpo (date): _____ ☐ LEEP (date):_____ ☐ Don't know ☐ None

LABEL

Date: ___ / ___ / _____

SECTION 7. HISTORY OF PREVIOUS PREGNANCIES (IF APPLICABLE)

Date	Weeks Carried	Pregnancy Result (circle one)	Type of Delivery (circle one)	Birth Weight	Place of Delivery	Complications
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			
		Live Birth Termination Miscarriage Stillborn	Vaginal C-section			

Did you have either of the following during pregnancy?

Diabetes? ☐ Yes ☐ No

High blood pressure? ☐ Yes ☐ No

- OFFICE USE ONLY -

Additional Significant Findings:

- OFFICE USE ONLY -

REVIEW NOTES	*INITIALS*	*DATE*	*REVIEW NOTES*	*INITIALS*	*DATE*
☐ *Reviewed, initial visit*			☐ *Reviewed, no changes*		
			☐ *Reviewed, changes as noted*		
☐ *Reviewed, no changes*			☐ *Reviewed, no changes*		
☐ *Reviewed, changes as noted*			☐ *Reviewed, changes as noted*		
☐ *Reviewed, no changes*			☐ *Reviewed, no changes*		
☐ *Reviewed, changes as noted*			☐ *Reviewed, changes as noted*		
☐ *Reviewed, no changes*			☐ *Reviewed, no changes*		
☐ *Reviewed, changes as noted*			☐ *Reviewed, changes as noted*		
☐ *Reviewed, no changes*			LABEL		
☐ *Reviewed, changes as noted*					
☐ *Reviewed, no changes*					
☐ *Reviewed, changes as noted*					
☐ *Reviewed, no changes*					
☐ *Reviewed, changes as noted*					

VISIT HEALTH HISTORY

Instructions: Complete at each visit (except follow-up visits).

Date: ___ / ___ / _____

SECTION 1. SEXUAL HEALTH

- OFFICE USE ONLY -

Date and initial each entry

1. What brings you to the clinic today? *(check all that apply)*
   - ☐ Screening/testing only (NO SYMPTOMS)
   - ☐ I have symptoms that are bothering me
     Please describe your symptoms: _____
   - ☐ I was told to come by a partner or someone else
     Who told you to come? _____
   - ☐ My partner told me he/she has an STI
     Please specify which STI: _____
   - ☐ For birth control or family planning services
   - ☐ Follow-up visit or treatment
   - ☐ Other reason: _____

2. When was the last time you had sex (vaginal, anal, and/or oral) without a condom?
   (Or when the condom broke or fell off during sex?) _____ / _____ / _____

3. How often do you use condoms?
   ☐ Never ☐ Sometimes ☐ Always ☐ Other: _____

4. What types of sex have you had in the ***last year***? *(check all that apply)*
   - ☐ My mouth on my partner's (☐ vagina ☐ penis ☐ anus ☐ other: _____)
   - ☐ My partner's mouth on my (☐ vagina ☐ penis ☐ anus ☐ other: _____)
   - ☐ My vagina on my partner's (☐ vagina ☐ penis ☐ mouth ☐ other: _____)
   - ☐ My partner's vagina on my (☐ vagina ☐ penis ☐ mouth ☐ other: _____)
   - ☐ My penis in/on my partner's (☐ vagina ☐ mouth ☐ anus ☐ other: _____)
   - ☐ My partner's penis in/on my (☐ vagina ☐ mouth ☐ anus ☐ other: _____)
   - ☐ Shared sex toys with my partner

5. How many sex partners have you had ... in the ***last 2 months***? _____
   … in the ***last year***? _____

6. Is your current sex partner with you today for their own visit? ☐ Yes ☐ No

7. Are you or your partner currently using any method(s) to prevent pregnancy?
   ☐ Yes ☐ No ☐ Don't know ☐ Not applicable

   If yes, what method are you using? _____

   If no, would you like to discuss birth control options today? ☐ Yes ☐ No

SECTION 2. IF ASSIGNED FEMALE AT BIRTH

- OFFICE USE ONLY -

Date and initial each entry

8. Are you currently pregnant? ☐ Yes ☐ No ☐ Don't know

9. Do you need emergency contraception today?
   (like the "morning after pill" or Plan B) ☐ Yes ☐ No ☐ Don't know

- OFFICE USE ONLY –

☐ *Interpreter or assistive services used* ☐ *Declined*

Name: _____

Title: _____ Number: _____

LABEL

Date: ___ / ___ / _____

SECTION 3. HEALTH SCREENING QUESTIONS				**- OFFICE USE ONLY -**
Please answer the following questions:	**In the past year**	**In your lifetime**	**Never**	*Date and initial each entry*
10. Have you had sex with a male?	☐	☐	☐	
11. Have you had sex with a female?	☐	☐	☐	
12. Have you had sex with a transgender individual?	☐	☐	☐	
13. Have you had sex with strangers?	☐	☐	☐	
14. Have you had sex with someone who has HIV/AIDS?	☐	☐	☐	
15. Have you had sex with a man who has sex with other men?	☐	☐	☐	
16. Have you had sex for drugs, money, or other things you needed?	☐	☐	☐	
17. Have you had sex with someone who exchanges sex for money, drugs, or other things they need?	☐	☐	☐	
18. Have you stayed in jail or prison?	☐	☐	☐	
19. Have you injected a drug not prescribed by a doctor?	☐	☐	☐	
20. Have you snorted drugs?	☐	☐	☐	
21. Have you shared equipment for injecting or inhaling drugs, steroids, hormones, silicone, or other substances?	☐	☐	☐	
22. Have you gotten a tattoo or piercing outside of a licensed parlor?	☐	☐	☐	
23. Have you had sex with someone who has hepatitis C?	☐	☐	☐	
24. Have you lived with, or had sex with, someone who has hepatitis B?	☐	☐	☐	
25. Have you been hit, slapped, choked, sexually abused, or otherwise physically hurt by anyone, including someone you were dating or going out with?	☐	☐	☐	
26. Has anyone made you have sex (vaginal, oral, or anal) when you didn't want to, including someone you were dating or going out with?	☐	☐	☐	

27. Have you had sex with someone you met through the internet or a mobile app?
☐ Yes ☐ No
If yes, which sites or apps have you used? _____

28. Do you think (or know) that your sex partner has been having sex with someone else?
☐ Yes ☐ No ☐ Don't know

29. Are you interested in medication to prevent HIV (*i.e.* PrEP or nPEP)?
☐ Yes ☐ No ☐ Unsure

30. Have you ever had a HIV test? ☐ No ☐ Yes: Date of last test? _____

31. Have you ever had a syphilis test? ☐ No ☐ Yes: Date of last test? _____

32. Please list any specific questions you have for the provider today:

Reminder*: Record any changes to the client's medical or STI history on the "General Health History" form.*

- OFFICE USE ONLY -

REVIEW NOTES	***INITIALS***	***DATE***
☐ *Reviewed, no changes*		
☐ *Reviewed, changes as noted*		
☐ *Reviewed, no changes*		
☐ *Reviewed, changes as noted*		

LABEL