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*					