COMPLETE MEDICAL HISTORY Date _____
WYANDOT COUNTY FAMILY PLANNING

All the information is confidential, please answer accurately and honestly.

Name _____ Date of Birth _____Age _____

Current Medications _____ Allergies _____

Surgeries/Hospitalizations_____

PERSONAL & FAMILY HISTORY (Please check line for each known history of illness)

	Self	Father	Mother	Siblings	Children
Anemia	_____				
Hepatitis B or C	_____				
Cystic Fibrosis	_____	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Digestive Problems	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Epilepsy/Convulsions	_____	_____	_____	_____	_____
Blood disease/Sickle cell	_____	_____	_____	_____	_____
Kidney/Bladder Disease	_____	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____	_____
Muscular dystrophy	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____
Down Syndrome	_____	_____	_____	_____	_____
Developmental Disability	_____	_____	_____	_____	_____
Birth Defects	_____	_____	_____	_____	_____
Tay-Sachs Disease	_____	_____	_____	_____	_____

Have you ever had a Blood Transfusion or Organ Transplant _____ If yes, what year? _____

I. SOCIAL/SEXUAL HISTORY

Do you have a non-professional tattoo?
Yes No

Do you have HIV?
Yes No

Do you smoke or use tobacco products (e-cigg, vapors)
Yes No
How much per day? _____

Do you use alcohol?
Yes No
How many drinks per week? _____

Have you used illegal injecting drugs, or shared needles?
Yes No

Have you used crack cocaine in the last year?
Yes No

Have you shared straws while snorting drugs?
Yes No

Are you a healthcare worker with exposure to blood?
Yes No

Do you have a history of exposure to blood not related to to your job *(fights, first aid to injured person)*
Yes No

Do you use street drugs? (*marijuana, etc)*
Yes No
How often? _____

Do you take prescription pills as your doctor has prescribed?
Yes No

Have you taken prescription pills that were <u>not</u> prescribed to you?
Yes No

Have you ever been sexually active?
Yes No

Are you currently sexually active?
Yes No

Do you engage in *Oral Vaginal Anal* sex?
(Circle all that apply)

Age at first intercourse _____

Your total number of sex partners _____

Your number of sex partners in the past 6 mos. _____

Do you have sex with *(circle one)*
Men Women Both

Have you had sex with a man who has had sex with a man?
Yes No Don't know

Have you had sex while under the influence of alcohol?
Yes No

Have you had sex while under the influence of drugs?
Yes No

Have you had sex for drugs or money?
Yes No

Have you had sex for food or shelter?
Yes No

Have you had sex with an IV drug user?
Yes No

Have you ever had an STD?
(HPV, GC, Chlamydia, Herpes, Syphilis, Genital warts, Hep B)
Yes No

When was your last HIV test? _____

How many times have you been tested for HIV?_____

Are you HIV positive?_____

Did your biological mom have HIV/AIDS when you were born? _____

Have you had sex with a **known** Hepatitis C positive partner?
Yes No Don't Know

Within past year have you been hit, slapped, kicked or hurt by anyone?
Yes No

Are you in a relationship with a person who threatens or physically hurts you?
Yes No

As a child or as an adult, has anyone touched you sexually in a way that you did not want to be touched?
Yes No

Has anyone forced you into sexual activity?
Yes No

Are you a victim of sexual assault?
Yes No

Has anyone forced you to have sex that made you feel uncomfortable?
Yes No

Have you had unwanted, forced sexual contact with someone in the past year?
Yes No
If yes, by whom? _____

Do you feel safe in your current relationship?
Yes No

1. Did you use a condom during **vaginal** intercourse during the last 12 months?
   Always Sometimes Never Don't know Doesn't apply
2. Did you use a condom during **anal** intercourse during the last 12 months?
   Always Sometimes Never Don't know Doesn't apply
3. Did you use a condom or barrier when performing **oral** sex during the last 12 months?
   Always Sometimes Never Don't know Doesn't apply

REPRODUCTIVE LIFE PLAN

1. Do you plan to have children in the future? _____
2. How many? _____
3. Do you want to become pregnant in the next year? _____
4. How long do you plan to wait to have children? _____
5. How many years do you plan to wait between children? _____
6. Do you want birth control today? _____

Females Only

Have you ever had an abnormal PAP test?
Yes No

Total number of times pregnant? _____
Date last pregnancy ended _____
How? _____

Live births # _____ Living now # _____
Abortions # _____ Miscarriages # _____
Stillborn # _____ Ectopic # _____

If you were born between 1940 – 1970
Did your mother take a medicine (DES) during her pregnancy? (*circle one)*
Yes No Don't Know

Age periods began _____
Length of period _____(days)
Number of days between periods _____
Are your periods usually regular? Yes No
Number of pads/tampons on heaviest day _____
Do you have bleeding between periods? Yes No
Do you have vaginal bleeding after sex? Yes No
Previous birth control method? _____
Any problems with this method? Yes No
If yes, what? _____
Current birth control method? _____
Any problems with this method? Yes No
If yes, what? _____

MENTAL HEALTH

During the past two or more weeks-------

Do you experience a persistent sad, anxious or "empty" mood?
Yes No

Do you sleep too little or are you sleeping too much? *(circle the one that applies)*
Yes No

Do you have loss of interest or pleasure in activities you once enjoyed?
Yes No

Do you feel restless or irritable?
Yes No

Do you have difficulty concentrating, remembering, or making decisions?
Yes No

Do you have unusual fatigue or loss of energy?
Yes No

Do you feel worthless, guilty, or hopeless?
Yes No

Do you have persistent physical symptoms that don't respond to treatment? *(such as headaches, chronic pain, constipation and other digestive disorders)*
Yes No

Do you have thoughts of death or suicide?
Yes No

Have you experienced reduced appetite and weight loss or increased appetite or weight gain?
Yes No

Are any of these symptoms severe enough to interfere with your daily routine?
Yes No

If you answered "Yes" to any of the above questions, please provide explanation.
_____
_____
_____

Additional
Comments:_____
_____