COMPLETE MEDICAL HISTORY
WYANDOT COUNTY FAMILY PLANNING

Date ______________________

Name ____ Date of Birth ____________Age _________

Current Medications ____

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	_____	_____	_____	__________	_________
Mental Retardation	_____	_____	_____	__________	_________
Birth Defects	_____	_____	_____	__________	_________
Tay-Sachs Disease	_____	_____	_____	__________	_________

Blood Transfusion or Organ Transplant _______ If yes, what year? _______

SOCIAL/SEXUAL HISTORY

Do you have a non-professional tattoo?
Yes No

Do you have HIV?
Yes No

Do you smoke or use tobacco?
Yes No
How much per day? ____________

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

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

Have you used illegal injecting drugs?
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 non-occupational exposure to blood*? (fights, first aid to injured person)*
Yes No

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

Have you ever been sexually active?
Yes No
Are you currently sexually active?
Yes No
Do you engage in *Oral* *Vaginal* *Anal* sex?
(Circle)
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 illegal drugs?
Yes No
Have you had sex for drugs or money?
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)
Yes No
How many times have been tested for HIV? _____
When was your last HIV test? ___________
Are you the child of a woman with HIV/AIDS?
Yes No

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 when you were the recipient of **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

Males Only

In the last 12 months, was a condom used when you were the inserter in rectal intercourse? *(circle one)*

Always Sometimes Never Don't know Doesn't apply

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 # _____

Did your mother take a medicine (DES) during her pregnancy? *(circle one)*
Don't know Yes No

REPRODUCTIVE LIFE PLAN

1. Do you want to have children? __________
2. How many? __________
3. How long do you plan to wait until having children? ___________
4. How much space do you plan between children? ___________
5. What can we do today to help you achieve your plan? _________

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 yes, how? ____

____

If the client answers "yes" to five or more of the above questions or if the symptoms are severe enough to interfere with his/her daily routine, refer to physician or agency.

Additional Comments:____

____

All the information you give is confidential.

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

_______________________________ _______________________________
Patient Signature/Date Provider's Signature/Date