Date:_____

Whiteside County Health Department
Family Planning Initial Medical History

Patient ID Sticker

Preferred Name: _____

Legal Name: _____

Preferred Pronoun: He/She/They/Other:_____

Please list the best way you can be contacted by the Whiteside County Health Department: _____

_____

SOCIAL HISTORY:

Yes____ No____ Do you smoke? If yes, how many cigarettes a day? _____
Yes____ No____ Do you drink alcohol beverages? If yes, how often _____how much_____
Yes____ No____ Do you use recreational drugs? If yes, list names_____ how often_____
Yes____ No____ Have you ever used IV drugs, even one time? If yes, list drug _____how often_____
Yes____ No____ Have you ever found yourself in a violent or coercive relationship? Comments_____

Gender Assigned at Birth: Male/Female
Gender Identity (circle one): Male/ Female/ Transgender MTF/ Transgender FTM/ Decline/Other:_____
Sexual Orientation (circle one): Lesbian/Gay/ Straight/Bi-sexual / Don't Know/ Decline/Other:_____

MENSTRUAL HISTORY

Age when periods started _____ How often do you have a period?_____
How long does your period last? _____ Average number of pads/tampons used each day _____
Date of your last period: _____
Do you have cramping with your periods? Always____ Sometimes____ Never____
Do you spot or bleed in between periods? Always____ Sometimes____ Never____
Age at first intercourse _____ Have you ever felt pressured to have sex? Yes ____ No ____
Date of last Pap_____ Was it normal? _____ Never had a Pap _____
Have you ever had an abnormal Pap? No____ Yes____ Date_____ Did you require treatment?_____
Do you examine your breasts for lumps? Yes____ No____ Have you noticed breast changes?_____

Pregnancy/Contraceptive History

Number of pregnancies: Live births____ Miscarriages____ Abortions____ Never been pregnant____
List any complications with pregnancy _____
Age of first pregnancy:_____ Please list year each pregnancy ended:_____
Are you currently breastfeeding? Yes ____ No____
Are you seeking pregnancy at this time? Yes____ No____
Have you had unprotected sex since your last period? Yes____ No____
Are you currently using any method of birth control? Yes, list_____ No ____
Have you had any problems with past birth control methods? Yes, List_____ No ____
What method of birth control would you like to receive today? _____

Family History

Have your parents, brothers or sisters had any of the following:

Heart Attack	Yes____	No____	Comments_____
Stroke	Yes____	No____	Comments_____
High B/P	Yes____	No____	Comments_____
High Cholesterol	Yes____	No____	Comments_____
Blood Clots	Yes____	No____	Comments_____
Cancer	Yes____	No____	Comments_____
Diabetes	Yes____	No____	Comments_____
Sickle Cell	Yes____	No____	Comments_____
Other	Yes____	No____	Comments_____

Did your mother take DES (hormone) during her pregnancy with you? Yes____ No____

Patient ID Sticker

Medical History

Please mark "Yes" or "No" for each of the items listed below:

Health Concern	Yes	No	Unknown	Comments
Headaches/Migraines				
Anxiety/Depression/Attempted Suicide				
Vision Problems				
Ear/Nose/Throat Problems				
Thyroid Problems				
Skin Problems: rashes, lesions, acne				
Asthma				
Tuberculosis (TB)				
Heart Problems				
Scarlet Fever/ Rheumatic Fever				
High Blood Pressure				
High Cholesterol				
Kidney Problems				
Testicular/Scrotal/Hernias				
Urinary Problems				
Chronic indigestion/heartburn				
Chronic Diarrhea/Constipation				
Hemorrhoids or Rectal Bleeding				
Hepatitis/Liver Disease				
Gallbladder Disease				
Diabetes				
Seizure Disorder/Epilepsy				
Arthritis				
Cancer				
Chronic Anemia				
Blood Clotting Disorders				
Stroke				
Pelvic Infection				
Blood transfusion prior to 1984				
Are your vaccines up to date for:				
Measles, Mumps, Rubella				
Tetanus, Diptheria, Pertusis				
Hepatitis B				
HPV				
Flu				
Other Health Problems				
List surgeries and dates:				
List all current prescription drugs and over the counter medications:				
List all allergies:				

Client Signature:_____ **Staff Signature:**_____

I verify that information provided is an accurate reflection of my health. **Date:**_____