Please complete the information on this form. All information is CONFIDENTIAL and will not be released unless you grant permission or as required by law.

PERSONAL HISTORY: (✓ Check all that apply)

☐ Insomnia  ☐ Blood clots in veins or lungs  ☐ Sickle cell disease  ☐ Bladder or kidney infections
☐ Sinus trouble  ☐ Chronic cough  ☐ Anemia  ☐ Infection in tubes/uterus (PID)
☐ Dizziness  ☐ Back problems  ☐ Liver disease  ☐ Tubal (ectopic) pregnancy
☐ Eye, ear, nose, throat trouble  ☐ Breast lump or tumor  ☐ Gall bladder disease  ☐ Vaginal infections
☐ Severe headaches  ☐ Nipple discharge  ☐ Diabetes  ☐ Recurrent diarrhea
☐ Stroke  ☐ Heart disease or chest pain  ☐ Hepatitis or jaundice  ☐ Ovarian tumors or cysts
☐ Seizure disorder  ☐ High blood pressure  ☐ Weight gain or loss  ☐ Rectal bleeding/irritation
☐ Thyroid disease  ☐ Bronchitis/Influenza  ☐ Cancer  ☐ Other:______________
☐ Neck Problems

Please list: Allergies_________________________________________ Current Medications:_________________________________________

FAMILY HISTORY (Give relationship if your parents, grandparents, brothers and/or sisters have had any of the following):

Relationship ___________________ Cancer   Relationship ___________________ Sickle cell anemia   Relationship ___________________ Pregnancy complications
                                    Relationship ___________________ Tuberculosis  Relationship ___________________ Blood disorders
                                    Relationship ___________________ Heart Attacks  Relationship ___________________ Drug allergies
                                    Relationship ___________________ Heart Disease  Relationship ___________________ Epilepsy
                                    Relationship ___________________ Stroke   Relationship ___________________ Diabetes
                                    Relationship ___________________ Hypertension  Relationship ___________________ Glaucoma

EMOTIONAL HEALTH

YES ☐  NO ☐  Self-esteem issues
YES ☐  NO ☐  Anxiety/Excessive Nervousness/Stress
YES ☐  NO ☐  Other:_________________________
YES ☐  NO ☐  Interested in psychological counseling?

SUBSTANCE USE

Amount Frequency

YES ☐  NO ☐  Alcohol_________________________
YES ☐  NO ☐  Smoking_________________________
YES ☐  NO ☐  Inject. Steroids___________________
YES ☐  NO ☐  Other Drugs(specify):_________________

INTERESTED IN PSYCHOLOGICAL COUNSELING? ☐

HEALTH PROMOTION (✓ Check the appropriate box)

YES ☐  NO ☐  Do you exercise 3 or more times
YES ☐  NO ☐  Have you had your cholesterol checked?
YES ☐  NO ☐  Do you have any questions regarding nutrition?
YES ☐  NO ☐  Do you have any concerns about your genitalia (i.e., sores, discharge, dysfunction, etc.)
YES ☐  NO ☐  Do you do monthly breast exams?
YES ☐  NO ☐  Have you ever had a mammogram?
YES ☐  NO ☐  Do you do monthly testicular exams?

IMMUNIZATION HISTORY

Date(s)

Tetanus_________________________
MMR___________________________
Flu Vaccine______________________
Hepatitis B_______________________
TB Screening_____________________

(Please continue on reverse side)

Primary Care Provider’s Use Only  → Review/Comments:
SEXUAL HISTORY

YES ☐ NO ☐ Have you ever had intercourse? If yes, age at first intercourse:_______

☐ Do you have any discomfort or pain during intercourse?

☐ Have you had unprotected intercourse in the past six months? (✓ Check all that apply)

☐ Genital warts ☐ Herpes ☐ Chlamydia ☐ Syphilis ☐ HIV/AIDS ☐ Gonorrhea

☐ Have you ever had a sexually transmitted disease? (✓ Check all that apply)

☐ Do you have any concerns about sex or your sexuality?

FEMALE HEALTH HISTORY: (Females only)

YES ☐ NO ☐ Have you had a gynecologic (pelvic) exam or Pap smear before? If yes, where? _________ when? _________

Results: ☐ Normal ☐ Abnormal Explain (If abnormal): _________

☐ Have you ever attended the Educational Session on Family Planning? If yes, _________

Date

MENSTRUAL HISTORY

Age menstruation (period) began: ________ years.

How many days between your menstrual periods? ________

☐ Do you soak more than 5 pads/tampons a day?

☐ Have your menstrual cycles been frequently irregular? If yes, what is the longest time you have gone between periods? ________

Are you troubled by:

☐ Bleeding between periods or after intercourse ☐ Depression/Anxiety

☐ Mid-cycle pains ☐ Breast tenderness/fullness

☐ Vaginal discharge, itching, irritation or sores ☐ Weight gain more than 5 lbs.

☐ Burning with urination ☐ Ankle swelling

☐ Severe cramping ☐ Headache

PREGNANCY HISTORY

☐ Have you ever been pregnant?

Total number of pregnancies ________

Number of miscarriages ________ Which year(s) ________

Number of live births ________ Which year(s) ________

Number of abortions ________ Which year(s) ________

CONTRACEPTIVE HISTORY: Please indicate which of these contraceptive methods you have used.

☐ “Pill” ☐ Condoms ☐ Diaphragm/Cervical Cap ☐ IUD ☐ Withdrawal

☐ Sponge ☐ Rhythm method ☐ Norplant ☐ Spermicidal ☐ Other:___________

What is your current birth control method?________________________________________

Are you satisfied with your current method?_____________________________________

If no, what method would you like to use?_____________________________________}

Have you had any problems or pregnancies while using any birth control method? If yes, which method(s)?

Students’ Name (Please print)____________________________________________________

Student’s Signature___________________________________________________________ Date________

Parent or Guardian’s Signature (If student is under age 18)_________________________ Date________

Primary Care Provider’s Use Only ➔ Review/Comments:

PCP Signature______________________________________________________________ Date________

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