This medical record is ***confidential*** and will not be released to anyone except as may be required by law.

St. Croix County DHHS-Public Health Dept.
Reproductive Health
1752 Dorset Lane, New Richmond, WI 54017
715-246-8365 Fax 715-246-8298

Date_____

Chart #_____

FEMALE MEDICAL HEALTH HISTORY

Name _____ Date of Birth _____/_____/_____ Age _____
Last First M

Reason for visit: _____

Please circle if you are allergic to: □ **No Allergies**
□ Penicillin □ Iodine □ Zithromax □ Doxycycline □ Sulfa □ Metal □ Rocephin
□ Tetracycline □ Latex □ Local anesthetic □ Amoxicillin □ Other_____

Have you or your partner recently traveled to a region with known Zika or Ebola transmission? Yes No If yes, where:_____

List medications, vitamins, over-the-counter drugs, and/or herbs you take:_____

Have you recently taken antibiotics? Yes No If yes, when _____ for what _____ what kind _____

MENSTRUAL HISTORY

Day last period began: _____ Was it normal? □Yes □No

Do you have bad cramps? □ Yes □ No

Do you bleed heavy? □ Yes □ No Age of first period: _____

Have you had sex since your period? □ Yes □ No

SEXUAL HISTORY

Have you ever had sex? □ Yes □ No (If no, go to next section.) Age of first intercourse: _____

Have you or your partner had more than one sexual partner in your lifetime? □ Yes □ No

Have you had a new sex partner or more than one partner in the last 90 days? □ Yes □ No □ Don't know

Has your partner(s) had a new sex partner or more than one partner in the last 90 days? □ Yes □ No □ Don't know

Have you ever engaged in a sexual activity where you felt you couldn't say no? □ Yes □ No

Circle if you have: □ vaginal sex □ oral sex □ anal sex □ sex with men □ sex with women □ sex with both

Circle if you have you ever had: □ Chlamydia □ Gonorrhea □ HPV/warts □ Herpes □ Syphilis

Have you or your partner(s) used IV drugs? □ Yes □ No □ Don't know

Have you had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days? □ Yes □ No

Has your partner had symptoms or diagnosis of a sexually transmitted infection in the last 90 days? □ Yes □ No □Don't know

PREGNANCY (If never been pregnant–go to next section.→)

How many times have you been pregnant? _____

Date(s) when your pregnancy(ies) ended _____

_____

Are you breastfeeding? □ Yes □ No

REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? □ Yes □ No

How many children do you hope to have? _____

How long do you plan to wait until you (next) become pregnant?

_____

What do you plan to do until you are ready to get pregnant?

_____

What can I do today to help you achieve your plan?

_____

CONTRACEPTIVE HISTORY

Do you ALWAYS use condoms? □ Yes □ No

Are you using birth control now? □ Yes □ No If yes, what kind _____

Do you want birth control today? □ Yes □ No If yes, what kind _____

What kind of birth control have you used in the past? _____

Any problems with those methods? _____

Does your sexual partner(s) agree with your decision to prevent pregnancy and use birth control at this time? Yes No

Has anyone ever done anything to your birth control? □ Yes □No (i.e., thrown away your pills, patches, rings, or taken his condom off before or during sex)

SOCIAL HISTORY

Do you smoke cigarettes? □ Yes □ No If yes, _____ # per day. Do you want to quit? □ Yes □ No

Do you drink alcohol? □ Yes □ No Do you use street drugs? □Yes □ No

Does alcohol/drugs cause problems in your life and/or are others concerned? □ Yes □ No

Do you feel threatened or afraid of someone in your life? □ Yes □ No

Have you ever received medical care/medications for your mental health? □ Yes □ No

Circle if have any concerns about: □ Date rape □ Forced/unwanted sex □ Physical abuse □ Weight

Name _____ Chart # _____

PAST MEDICAL HISTORY

Have you ever been in the hospital? □ Yes □ No If yes, why _____
Do you have a doctor? □ Yes □ No If yes, doctor's name _____
Date of your last pap smear: _____ What clinic: _____
List any medical problems: _____
Do you now have or have you ever had:

Yes	No		Yes	No		Yes	No	
□	□	Abnormal pap test	□	□	Endometriosis or ovarian cysts	□	□	Pelvic Infection/PID
□	□	Anemia	□	□	Gall bladder disease	□	□	Sickle cell anemia, trait of Thalassemia
□	□	Asthma	□	□	Genetic condition	□	□	Stroke
□	□	Breast surgery or disease	□	□	Heart disease/high blood pressure	□	□	Thrombophlebitis/blood clot(s)
□	□	Cancer	□	□	High cholesterol	□	□	Tuberculosis
□	□	Diabetes	□	□	Mono or Hepatitis	□	□	Uterine growth/fibroid
□	□	Diagnosis w/HIV/AIDS	□	□	Mitral Value Prolapse (MVP)	□	□	Seizure disorder/epilepsy
□	□	Blood disorders/problems with your blood	□	□	DES Exposure	□	□	Bariatric surgery

FAMILY HISTORY *(If you are adopted and do not know your family's medical history, go to next section.)*

Does your mother, father, brother, or sister have any of the following:

Stroke	□ Yes	□ No	Diabetes	□ Yes	□ No	Breast Cancer	□ Yes	□ No
Heart Attack	□ Yes	□ No	High Cholesterol	□ Yes	□ No	Ovarian Cancer	□ Yes	□ No
Blood Clot	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Prostate Cancer	□ Yes	□ No

REVIEW OF SYSTEMS

A. General

Yes	No	
□	□	Recent weight gain or loss (+/- 25 lbs)
□	□	Reactions to drugs or foods

B. Cardiovascular

Yes	No	
□	□	Chest pain
□	□	Palpitations
□	□	Varicose Veins

C. Genitourinary

Yes	No	
□	□	Blood in urine
□	□	Pain or burning with urination
□	□	Frequent urination
□	□	Vaginal discharge, itching, irritation, odor
□	□	Bumps, sores, rash in vaginal area
□	□	Have you urinated in past hour?
□	□	Do you have pain with sex?

D. Skin

Yes	No	
□	□	Acne
□	□	Rash/itching
□	□	Night sweats/hot flashes/fever/chills
□	□	Other skin problems

E. Breasts

Yes	No	
□	□	Breast lump
□	□	Breast pain
□	□	Nipple discharge

F. Eye, Ears, Nose, Throat

Yes	No	
□	□	Hearing problems
□	□	Frequent nose bleeds
□	□	Frequent sore throat
□	□	Thyroid problems
□	□	Blurred vision/double vision

G. Respiratory

Yes	No	
□	□	Chronic cough
□	□	Shortness of breath/ breathing problems

H. Neuro/Psych

Yes	No	
□	□	Convulsions / Seizures
□	□	Difficulty with memory or speech
□	□	Emotional problems
□	□	Sadness
□	□	Nervousness
□	□	Numbness/tingling
□	□	Headaches

I. Musculoskeletal

Yes	No	
□	□	Muscle or bone pain
□	□	Back pain

J. Gastrointestinal

Yes	No	
□	□	Abdominal pain
□	□	Nausea/vomiting
□	□	Changes in bowel habits
□	□	Changes in appetite
□	□	Constipation/diarrhea
□	□	Rectal pain or bleeding

K. Immunizations (check all you've had)

□ Tetanus □ Hepatitis A □ Pertussis □ Gardasil/HPV
□ Hepatitis B □ Meningococcal
□ Mumps/Measles/Rubella □ Chicken Pox

DIET & EXERCISE:

of servings of the following/per day: _____Dairy _____Protein _____Vegetables _____Fruits _____Grains
How many meals do you eat a day? _____ How much coffee, tea and soda per day? _____
What do you do for physical activity? _____ How many hours of sleep do you get?_____

To the best of my knowledge the above information is complete and correct.
Patient Signature _____ Date _____/_____/_____

Staff notes: _____ Face-to-Face time _____ Ed & Counseling time _____

Staff Signature: _____ Date _____/_____/_____