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
- Sinus trouble
- Dizziness
- Eye, ear, nose, throat trouble
- Severe headaches
- Stroke
- Seizure disorder
- Thyroid disease
- Neck Problems
- Blood clots in veins or lungs
- Chronic cough
- Back problems
- Breast lump or tumor
- Nipple discharge
- Heart disease or chest pain
- High blood pressure
- Bronchitis/Influenza
- Seizure disorder
- Self-esteem issues
- Anxiety/Excessive Nervousness/Stress
- Other:__________________
- Interested in psychological counseling?
- Bladder or kidney infections
- Anemia
- Liver disease
- Gall bladder disease
- Diabetes
- Recurrent diarrhea
- Hepatitis or jaundice
- Ovarian tumors or cysts
- Tubal (ectopic) pregnancy
- Vaginal infections
- Recurrent diarrhea
- Weight gain or loss
- Rectal bleeding/irritation
- Type

Please list: Allergies_________________________________________ Current Medications:_________________________________________

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

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Cancer</th>
<th>Tuberculosis</th>
<th>Sickle cell anemia</th>
<th>Pregnancy complications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EMOTIONAL HEALTH

YES NO
- Self-esteem issues
- Anxiety/Excessive Nervousness/Stress
- Other:__________________
- Interested in psychological counseling?
- Alcohol________________________
- Smoking________________________
- Inject. Steroids__________________
- Other Drugs(specify):_________________

SUBSTANCE USE

<table>
<thead>
<tr>
<th>Amount</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>__________</td>
</tr>
<tr>
<td>Smoking</td>
<td>__________</td>
</tr>
<tr>
<td>Inject. Steroids</td>
<td>__________</td>
</tr>
<tr>
<td>Other Drugs(specify)</td>
<td>__________</td>
</tr>
</tbody>
</table>

HEALTH PROMOTION (✓Check the appropriate box)

YES NO
- Do you exercise 3 or more times a week for 20 or more minutes?
- Have you had your cholesterol checked?
- Do you have any questions regarding nutrition?
- Do you have any concerns about your genitalia (i.e., sores, discharge, dysfunction, etc.)?
- Do you do monthly breast exams?
- (Females) Have you ever had a mammogram?
- (Males) Do you do monthly testicular exams?
- 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?
☐ ☐ Have you ever had a sexually transmitted disease? (☑Check all that apply)
☐ Genital warts ☐ Herpes ☐ Chlamydia ☐ Other:____________________
☐ Syphilis ☐ HIV/AIDS ☐ Gonorrhea
☐ ☐ Do you have any concerns about sex or your sexuality?

FEMALE HEALTH HISTORY: (Females only)

YES ☐ NO ☐ PREVIOUS EXAMS
☐ ☐ 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

YES ☐ NO ☐ 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)?________________________________________