Here for YOU
YOUR SEXUAL HEALTH MATTERS

Personal Medical and Reproductive Health History

☐ **New Patient** ☐ **Established Patient**

Past History: (*Check all that apply)*

☐ Acid reflux	☐ Cancer	☐ Headaches	☐ Migraines
☐ Alcohol or Drug problems	☐ Colitis	☐ Heart disease	☐ Osteoporosis
☐ Allergy problems	☐ Crohn's disease	☐ Heart valve problems	☐ Skin infections
☐ Anemia	☐ Depression, Anxiety	☐ Hepatitis	☐ Recurrent UTI
☐ Artery problems	☐ Diabetes	☐ High blood pressure	☐ Seizures
☐ Arthritis	☐ Emphysema	☐ High cholesterol	☐ Sexually transmitted infection
☐ Asthma	☐ Other lung disease	☐ Irritable bowel	☐ Stroke
☐ Autoimmune disease	☐ Esophagitis, ulcers	☐ Kidney stones	☐ Thyroid disease
☐ Bleeding problems	☐ Gallstones	☐ Kidney disease	☐ Vein problems
☐ Blood clots	☐ Glaucoma	☐ Liver disease	☐ Currently breastfeeding

☐ Other diseases not listed _____

☐ **Explain any of the above if necessary** _____

_____

☐ **Hospitalizations** _____

Surgery/Procedures: *(Check all that apply)*

☐ Appendix	☐ Heart surgery	☐ Tonsils and/or adenoids
☐ Bladder	☐ Bypass	☐ Tubal ligation
☐ Blood vessel surgery	☐ Heart valve surgery	☐ Vasectomy
☐ Dental surgery	☐ Angioplasty (balloon)	☐ Hysterectomy
☐ Eye surgery	☐ Stents	☐ Complete
☐ Gallbladder	☐ Joint replacement	☐ Partial (ovaries preserved)
☐ Kidney stone	☐ Orthopedic surgery	☐ Prostate surgery

☐ Other significant surgery not listed: _____

☐ **Significant injuries**: _____

Medication List: (Include all prescribed or over-the-counter medications, vitamins, supplements, or herbal medicine)

Name	Dose	Frequency	Disease or Reason

Allergies (medications, foods, latex, IV dye)	Reactions

Family History	Living	Deceased	Medical conditions/disease
Father			
Mother			
Brother(s) #			
Sister(s) #			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Children #			

Adopted ☐ Yes ☐ No

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Social History

Select the option that best describes your gender
☐ Male ☐ Female ☐ Transgender ☐ Other

Employment status
☐ Employed ☐ Self-employed ☐ Unemployed ☐ Retired
☐ Unable to work or disabled ☐ Military
Occupation _____

Do you smoke?
☐ Currently _____ packs/day for _____ year(s)
☐ Past/former smoker
☐ Never
☐ Other tobacco use _____

If you do smoke, would you like information about our smoking cessation program? ☐ Yes ☐ No ☐ N/A

Do you drink alcohol? ☐ Yes ☐ No
☐ Beer ☐ Wine ☐ Liquor
How many drinks per week? _____

In your lifetime, have you ever used illegal drugs, marijuana or prescription drugs not prescribed to you? ☐ Yes ☐ No
Type: _____
Date of last use: _____

Do you feel safe in your current relationship and/or home?
☐ Always ☐ Sometimes ☐ Never ☐ N/A

How often do you get the social and emotional support you need?
☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Have you ever been emotionally, physically, or verbal assaulted by someone? ☐ Yes ☐ No

Have you ever been forced to do something sexually that you didn't want? ☐ Yes ☐ No

Have you ever had sexual intercourse under the influence or alcohol and/or drugs? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No

Date of your last sexual activity: _____
☐ With condom ☐ without condom

How many sexual partners have you had in the past
3 months?: _____ 12 months: _____ Lifetime: _____

Have you ever had
☐ Oral sex (mouth on genitals or anus)
☐ Vaginal sex
☐ Anal sex (penis in anus or rectum)

Have you ever had a sexual experience with a:
☐ Male ☐ Female ☐ Both ☐ Transgender person ☐ N/A

Select the option that best describes your sexual identity:
☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Questioning
☐ Pansexual ☐ Asexual ☐ Other _____

Do you use condoms? ☐ Yes ☐ No ☐ Sometimes

Do you want to have a child in the next 12 months? ☐ Yes ☐ No

What method do you use to prevent pregnancy?
☐ Hormonal Implant (Nexplanon or Implanon)
☐ IUD (Intrauterine device)
☐ Vaginal Ring (NuvaRing)
☐ Patch
☐ Oral Contraceptives (Pills)
☐ Pull-Out Method
☐ Abstinence (choose not to have sex)
☐ Condoms (for men and women)
☐ Depo-Provera injection
☐ Fertility Awareness (menstrual tracking)
☐ Spermicides (Foam, Film, Gel, Cream)
☐ Sterilization (Essure, hysterectomy, vasectomy, tubal ligation)
☐ Other _____
☐ No Method

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For our FEMALE patients only:

Age at first period: _____ years ☐ N/A

First day of last menstrual period: _____ ☐ N/A

Duration of menstrual bleeding: _____ days ☐ N/A

Age at first sexual intercourse: _____ years ☐ N/A

Have you ever had an abnormal Pap smear?
☐ Yes - **If YES,** when _____ ☐ No ☐ Never had a Pap smear

Have you ever had an abnormal mammogram?
☐ Yes – **If YES,** when _____
☐ No
☐ Never had a mammogram

Total number of pregnancies: _____
Total number of live births: _____
Total number of miscarriages: _____
Total number of abortions: _____

Delivery Type(s) - *Select all that apply*
☐ Vaginal delivery
☐ Cesarean section (C-section)
☐ Vaginal birth after Cesarean (C-section)

Complications during pregnancy? ☐ Yes ☐ No
Describe: _____

Preterm births? ☐ Yes ☐ No
Number of weeks: _____