UNION COUNTY
HEALTH DEPARTMENT

Nursing Clinic
Personal Medical and Reproductive Health History

☐ New Patient ☐ Established Patient

Patient's Full Name: ______________________________ **Date of Birth:**____________________

MEDICAL HISTORY:

☐ Acid reflux
☐ Alcohol or Drug problems
☐ Allergy problems
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Autoimmune disease
☐ Bleeding problems
☐ Blood clots (DVT)
☐ Other: ____
☐ Cancer
☐ Colitis
☐ Crohn’s disease
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Other lung disease
☐ Esophagitis, ulcers
☐ Gallstones
☐ Glaucoma
☐ Headaches
☐ Heart disease
☐ Heart valve problems
☐ Hepatitis
☐ High blood pressure
☐ High cholesterol
☐ Irritable bowel
☐ Kidney stones
☐ Kidney disease
☐ Liver disease
☐ Mental health condition(s)
☐ Migraines
☐ Osteoporosis
☐ Skin infection
☐ Recurrent UTIs
☐ Seizures
☐ Sexually transmitted disease
☐ Stroke
☐ Thyroid problem
☐ Currently breastfeeding

HOSPITALIZATIONS: ____

SURGERIES/PROCEDURES:

☐ Appendix
☐ Bladder
☐ Breast
☐ Dental surgery
☐ Eye surgery
☐ Ear surgery
☐ Gallbladder
☐ Kidney stone
☐ Heart surgery
☐ Hernia
☐ Hysterectomy - Complete
☐ Hysterectomy - Partial
☐ Joint replacement
☐ Orthopedic surgery
☐ Prostate
☐ Tonsils and/or adenoids
☐ Tubal ligation
☐ Vasectomy
☐ Implants or medical devices
☐ Cosmetic
☐ Other: _________________________

MEDICATIONS (prescribed or over-the-counter medications, vitamins, supplements, or herbal medicine)

NAME	DOSE	FREQUENCY

ALLERGIES

NAME	REACTION

FAMILY HISTORY

	Living	Deceased	Medical Conditions/Diseases
FATHER			
MOTHER			
SIBLINGS	#	#	
CHILDREN	#	#	
PATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
MATERNAL GRANDMOTHER			

Adopted ☐ Yes ☐ No

SOCIAL HISTORY

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

What is your marital status?
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

What is your employment status?
☐ Employed ☐ Self-employed ☐ Unemployed ☐ Retired
☐ Unable to work or disabled ☐ Military
Occupation: ____

Do you feel safe going home today? ☐ Yes ☐ No

Does your partner <u>ever</u> make you feel afraid? ☐ Yes ☐ No

Does your partner <u>ever</u> hit you, hurt you or threaten you? ☐ Yes ☐ No

Have you <u>ever</u> been forced to have sex or do something sexually that you didn't want to do? ☐ Yes ☐ No

Have you ever had sex for money, drugs or something else that you needed? ☐ Yes ☐ No

SMOKING AND TOBACCO USE

Do you smoke cigarettes?
☐ Yes #_____ cigarettes/day for #____ year(s)
☐ No ☐ Former Smoker

Do you vape or juul? ☐ Yes ☐ No
Do you use smokeless tobacco? ☐ Yes ☐ No
Do you smoke marijuana? ☐ Yes ☐ No

Would you like information about smoking cessation? ☐ Yes ☐ No

ALCOHOL AND SUBSTANCE USE

Do you drink alcohol? ☐ Yes ☐ No
How many drinks per <u>day</u>? ________ ☐ Beer ☐ Wine ☐ Liquor
How many drinks per <u>week</u>? _______ ☐ Beer ☐ Wine ☐ Liquor

Have you <u>ever</u> used drugs, marijuana or prescription drugs not prescribed to you? ☐ Yes ☐ No
What type of drugs? ___________________________
Date of last use: _________________

SEXUAL HISTORY

Have you ever had sexual intercourse? ☐ Yes ☐ No

Date of 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 ☐ Transgender person ☐ N/A

Select which option best describes your sexual orientation:
☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian
☐ Questioning ☐ Pansexual ☐ Asexual ☐ Other

How old is your current sexual partner? ______

Do you use condoms? ☐ Always ☐ Sometimes ☐ Never

Have you ever used PrEP? ☐ Yes ☐ No

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

What method do you currently use to prevent pregnancy?
☐ Hormonal Implant (Nexplanon)
☐ IUD (intrauterine device- Mirena, Skyla, Kyleena, Liletta, Paragard)
☐ Vaginal Ring (NuvaRing)
☐ Patch (Xulane)
☐ Oral Contraceptives (Pills)
☐ Pull-Out Method (Withdrawal)
☐ Abstinence (Choose not to have sex)
☐ Condoms (for men and women)
☐ Depo-Provera (the shot)
☐ Fertility Awareness (menstrual tracking)
☐ Spermicides (Foam, Film, Gel, Cream)
☐ Sterilization (Hysterectomy, Vasectomy, Tubal ligation)
☐ No Method
☐ Rely on Partner's method
☐ Other _________________________

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For our FEMALE patients only:

Age at first period: ______ **years**

Age at first intercourse: _____ **years**

First day of last menstrual period: __________

Duration of menstrual bleeding: _____ **days**

When was your last Pap smear? __________

Have you ever had an abnormal Pap smear?
☐ Yes ☐ No ☐ Never had a Pap smear

Have you ever had an abnormal mammogram?
☐ Yes ☐ 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)

Where did you deliver? ________________________

Complications during pregnancy? ☐ Yes ☐ No
Describe: __________________________________

Preterm births? ☐ Yes, **Number of weeks:** ________ ☐ No