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

[For OFFICE USE ONLY]

Client Name:_____
Client No._____
DATE: _____/_____/_____

Oneida Co. Health Department-
Reproductive Health Clinic
100 W. Keenan Street Rhinelander WI 54501
PH: 715-369-6116 Fax: 715-369-2553

Female - MEDICAL HEALTH HISTORY

Name:_____ Date of Birth ____/____/_____ Age _____
(Last) (First) (MI) mm / dd / yyyy
Reason for visit_____

Please circle if you are allergic to:
□Penicillin □Iodine □Zithromax □Doxycycline □Sulfa □Metal □Rocephin □Tetracycline □Latex
□Amoxicillin □Local anesthetic □ No Allergies □Other(s): _____

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 when periods started: _____
Have you had sex since your period? ___Yes ___ No

SEXUAL HISTORY: Have you ever had sex? ___Yes ___ No
Have you had more than one sexual partner in your lifetime? __Yes __No
Have you had a new sex partner in the last 90 days? ___ Yes ___ No
Has your partner had a different sex partner in the last 90 days? ___ Yes ___ No ___ Don't know
Have you had more than one partner in the last 90 days? ___ Yes ___ No
Check if you have: □Vaginal sex □ Oral sex □ Anal sex □ Sex with men □ Sex with women □ Sex with both
Check if you have ever had: □ Chlamydia □ Gonorrhea □ HPV/warts □ Herpes □ Syphilis
Have you or your partner(s) used illegal 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 a diagnosis of a sexually transmitted infection in the last 90 days? __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?
_____

PREGNANCY HISTORY:
(If never pregnant, go to next section.)
How many times have you been pregnant?____
Dates when pregnancy(ies) ended:_____
_____
Are you breastfeeding? ___Yes ___ No

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?_____

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
Check if you have any concerns about: □Date rape □Forced/unwanted sex □ Physical abuse □ Weight
Have you ever received medical care/medications for your mental health? ___Yes ___ No

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 : _____
List any medical problems: _____
Date of your last pap smear? _____ What Clinic?_____

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Client Name:_____
Client No._____
DATE: _____/_____/_____

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 Thalassemi
___	___	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
□ Rubella □ Hepatitis B □ Meningococcal
□ Measles □ Mumps □ Chicken Pox

DIET & EXERCISE: # of servings of the following/per day :___Dairy ___Protein ___ Carbs
How many meals do you eat a day?_____ How much coffee, tea and soda per day?_____
What do you do for exercise?_____ 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:_____ Counseling Time:_____

Staff Signature: _____ Date _____/_____/_____

(updated 2-14-/2013)