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

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

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

PREGNANCY HEALTH HISTORY

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

Are you allergic to:
☐Penicillin ☐Iodine ☐Zithromax ☐Doxycycline ☐Sulfa ☐Rocephin ☐Metal ☐Tetracycline
☐Amoxicillin ☐ Latex ☐Local anesthetic ☐No Allergies ☐other(s): _____
List medications, vitamins, over-the-counter drugs, and/or herbs you take:

REASON FOR YOUR VISIT – PREGNANCY TESTING: *Please answer the following questions:*
Are you planning a pregnancy at this time? ___Yes ___No
If you are pregnant, will you feel? ___Happy ___Not sure ___Sad ___Worried Other:_____
If you are pregnant, will you proceed with the pregnancy? ___Yes ___No ___Uncertain
Check if you will want information on or assistance with: ☐Financial assistance ☐Nutrition (WIC) ☐Prenatal care
☐Abortion ☐Adoption ☐Infant care ☐Parenting

MENSTRUAL HISTORY
When was the 1st day of your last period: _____/____/_____ Was it Normal? ___Yes ___No
Have you had sex since your last period? ___Yes ___No
Since your last period, have you had any of the following? (check all that apply): ☐ breast tenderness ☐ fatigue
☐ increased urination ☐ nausea or vomiting ☐ pain in your lower abdomen

SEXUAL HISTORY Age of first intercourse: _____
Have you had more than one partner? ___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
Circle if you have: Vaginal sex Oral sex anal sex Sex with men Sex with women Sex with both
Circle if you have ever had: Chlamydia Gonorrhea HPV/warts Herpes Syphilis HIV

PREGNANCY
How many times have you been pregnant? _____
Dates when your pregnancy(ies) ended _____
_____
Have you ever had an ectopic (tubal) pregnancy?
___Yes ___No
Are you currently 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?
_____

CONTRACEPTION:
Are you currently using a birth control method? ___No ___Yes, what kind: _____
When did you last use birth control: _____
If your pregnancy test is negative, do you want a method of birth control today? ___No ___Yes, what kind? _____

SOCIAL HISTORY
Do you smoke? ___No ___Yes ____# per day. Do you want to quit? ___No ___Yes
Do you drink alcohol? ___No ___Yes Do you use street drugs? ___No ___Yes
Does alcohol/drugs cause problems in your life and/or are others concerned? ___No ___Yes
Do you feel threatened or afraid of someone in your life? ___No ___Yes
Do you have any concerns about: ___Date rape ___Forced/unwanted sex ___Physical abuse ___Weight
Have you ever received medical care/medications for your mental health? ___No ___Yes

PAST MEDICAL HISTORY
Do you have a health care provider if you are pregnant? ___No ___Yes
If yes, name & clinic: _____

To the best of my knowledge, the above information is complete and accurate and I request a pregnancy test.

SIGNATURE OF PATIENT: _____ **Date: _____/_____/_____**

STAFF COMMENTS: _____
Total Face to face time:_____ Counseling time:_____
STAFF SIGNATURE _____ Date: _____/_____/_____ (UPDATED 10/5/2012)