

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month	Day Year
4. Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White		
5. Ethnic Origin <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported		
6. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
7. County of Residence		
8. Home Address:	9. Marital Status:	

CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

**FEMALE REPRODUCTIVE
HEALTH HISTORY**

Date: _____

A. GENERAL INFORMATION (Please complete the following)

1. What is the reason for your visit today? _____
2. Emergency contact: _____
3. May we contact you by mail? Yes No By phone? Yes No Your phone number is _____
4. Do you have a primary care provider? Yes No If yes, who? _____
5. Highest grade completed in school _____
6. Occupation _____
7. Special Needs/Primary Language _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you take a multivitamin with folic acid? Yes No Take any medications (prescription or over the counter), diet or herbal supplements? Yes No If yes, what? _____
3. Self and Family Medical History: Put an **X** under **SELF** and/or **X** under **FAMILY** (parent, grandparent, brother, sister or your child)

SELF	FAMILY		SELF	FAMILY	
<input type="checkbox"/>	<input type="checkbox"/>	1. Anemia/Sickle Cell Disease or Trait/Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	9. Hepatitis/Liver problems
<input type="checkbox"/>	<input type="checkbox"/>	2. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	10. Migraine headaches
<input type="checkbox"/>	<input type="checkbox"/>	3. Diabetes (if postpartum and had GDM, then repeat screening)	<input type="checkbox"/>	<input type="checkbox"/>	11. Cancer
<input type="checkbox"/>	<input type="checkbox"/>	4. Hypertension/High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	12. Blood clots in legs or lungs
<input type="checkbox"/>	<input type="checkbox"/>	5. Thyroid/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	13. Mental illness/Emotional disorders
<input type="checkbox"/>	<input type="checkbox"/>	6. Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	14. Transfusions of blood or blood products
<input type="checkbox"/>	<input type="checkbox"/>	7. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	15. Birth defects/Genetic problems
<input type="checkbox"/>	<input type="checkbox"/>	8. Seizure Disorders	<input type="checkbox"/>	<input type="checkbox"/>	16. Tuberculosis

If yes to any of the above, please explain: _____

C. GYNECOLOGICAL HISTORY

1. Menstrual history: At what age did you start your period? _____ How often do you have your period? _____
Any problems? _____
2. Any history of female conditions such as endometriosis, ovarian cysts, chronic pelvic pain, etc.? _____
3. Breast problems such as breast lumps, biopsies, surgeries? _____
4. Mammograms done/date _____
5. Date of last Pap test _____ History of any abnormal Pap tests? Yes No If yes, what was done and in what year?

D. OBSTETRICAL HISTORY

- 1. Total pregnancies _____ # Living _____ # Preterm _____ # Abortion _____ # Miscarriage _____
- 2. Date of last pregnancy _____
- 3. IF POSTPARTUM, advised to delay future pregnancy for 18 months to 5 years.

E. SEXUAL HISTORY (This section lends itself to being a self [patient completed] or a dialogue with the provider)

- 1. Do you have sex with? Men only Women only Both men and women
- 2. In the past two months, how many partners have you had sex with? _____
- 3. In the past 12 months, how many partners have you had sex with? _____
- 4. Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you? Yes No
- 5. What do you do to protect yourself from STDs and HIV? _____
- 6. What ways do you have sex? vaginal oral anal
- 7. Do you or your partner use condoms and/or dental dams every time you have vaginal, oral or anal sex? Yes No
- 8. Have you ever had an STD? Yes No If yes, which STD and when? _____
- 9. Have any of your partners had an STD? (i.e., chlamydia, gonorrhea, trichomoniasis, herpes, syphilis, hepatitis B, others) Yes No
If yes, which STD and when? _____
- 10. Have you or any of your partners ever injected drugs? Yes No
- 11. Have you or any of your partners exchanged money or drugs for sex? _____
- 12. Have you had a HIV test? Yes No If so, when? _____
- 13. Do you wish to have a HIV test today? Yes No

F. SOCIAL HISTORY

- 1. Do you smoke or use smokeless tobacco? Yes No If yes, how much? _____ How long? _____
- 2. Drink alcohol? Yes No If yes, how much? _____ How long? _____
- 3. Take street drugs? Yes No If yes, how much? _____ How long? _____

G. MENTAL HEALTH HISTORY

- 1. During the past two weeks, have you often been bothered by either of the following two problems?
 - a. Feeling down, depressed, irritable or hopeless Yes No or
 - b. Little interest or pleasure in doing things Yes No
- 2. Are you in a relationship with a person who threatens or physically hurts you? Yes No
- 3. In the past year, have you been slapped, kicked or otherwise physically hurt by someone? Yes No

H. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = up-to-date; REF = referred, and NA = not applicable)

Td/Tdap <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA	MMR <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA	Varicella <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA	HPV <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA	Hepatitis A <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA
Hepatitis B <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA	Meningococcal <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA	Pneumonia <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA	Influenza <input type="checkbox"/> UTD <input type="checkbox"/> REF <input type="checkbox"/> NA	

Source of Information: NCIR Patient Other Written Documentation

Interviewer's Signature: _____

Date: _____

Signature of Interpreter (if used): _____

Date: _____