

F. Do You:

- 1. 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, what? _____ How long? _____
- 4. Take vitamins with folic acid Yes No
- 5. Take diet or herbal supplements Yes No If yes, what? _____
- 6. Take any medications (prescription or over the counter) Yes No If yes, what? _____

BOTH MEN AND WOMEN:
G. APPETITE/DIETARY/EXERCISE/SAFETY INFORMATION
Do You:

- 1. Eat 5 fruits and vegetables a day? Yes No
- 2. Eat fewer than 2 meals a day? Yes No
- 3. Have trouble getting food? Yes No
- 4. Want to eat non-food items like dirt, clay, starch? Yes No
- 5. Exercise regularly (walk, swim, bike or other activity 30 minutes 3X/week)? Yes No
- 6. Have contact with chemicals/other hazards? Yes No
- 7. Use seatbelt while driving/riding in car? Yes No
- 8. Notice a weight change of more than 10 lbs? Yes No
- 9. Live in a safe place? Yes No
- 10. Smoke detectors at home? Yes No
- 11. Have exposure to second hand smoke? Yes No
- 12. Have problems with transportation? Yes No

H. SEXUAL & CONTRACEPTIVE HISTORY

- 1. Age at first intercourse? _____
- 2. Date of last intercourse? _____
- 3. Number of partners in past 6 months? _____
- 4. How many sexual partners have you had? _____
- 5. Do you use condoms every time you have sex? Yes No
- 6. Do you have sex with: Men only Women only Both men and women
- 7. Do you have pain or bleeding with sex? Yes No
- 8. Do you inject any drugs? Yes No
- 9. Have you had an HIV test? Yes No
If yes, when? _____
- 10. Do you want HIV testing today? Yes No
- 11. Does your partner use drugs? Yes No
- 12. Check the ways you have sex: vaginal oral anal
- 13. Have you had recent chills or fever? Yes No
- 14. Have you or your partner ever had a sexually transmitted disease (Gonorrhea, Chlamydia, Syphilis, Herpes, other)? Yes No
(If yes, please circle which sexually transmitted disease)
- 15. What have you used for birth control in the past?
 Pills Depo Shots Foam/Gel Diaphragm IUD
 Condoms Withdrawal (Pull out) Abstain Other None
- 16. What are you using now? _____
- 17. Are you satisfied with method? Yes No
- 18. If no, what method do you wish? _____
- 19. Do you or your partner want to become pregnant?
 Yes No If yes, when? _____

WOMEN ONLY:
I. MENSTRUAL/GYNECOLOGICAL HISTORY

- 1. What age did your menstrual periods begin? _____
- 2. When did your last period start? _____
- 3. How many days did it last? _____
- 4. Was it normal? Yes No
- 5. How often do you have your periods? _____
- 6. Any problems? _____
- 7. Do you douche Yes No
- 8. Do you have a vaginal discharge or odor? Yes No
- 9. Do you examine your breasts? Yes No
If yes, how often? _____
- 10. Have you ever had a pelvic exam? Yes No
If yes, date of last pelvic exam _____
- 11. Date of your last Pap smear _____
- 12. Have you ever had an abnormal Pap? Yes No
- 13. Have you ever had a mammogram? Yes No
If yes, date of last mammogram _____

J. OBSTETRICAL HISTORY

- 1. Have you ever been pregnant? Yes No
If yes, how many times? _____
- 2. How many were:
Full term? ____ Premature? ____ Stillborn? ____
- 3. How many times did you have:
A miscarriage? ____ An abortion? ____
- 4. Did any babies weigh less than 5½ lbs. at birth? Yes No
- 5. Did any babies weigh more than 9 lbs at birth? Yes No
- 6. Are you breast feeding now? Yes No
- 7. Did your mother take DES (Diethylstilbestrol) when she was pregnant with you? Yes No
- 8. Did you have a positive Group B Strep test with a previous pregnancy? Yes No
- 9. Did you have any problems with any pregnancies? Yes No

Provider/Nurse Comments ONLY:

Patient's Signature: _____ Date: _____

Signature of Interpreter (if used): _____ Date: _____

Reviewed By: _____ (Date) _____ (Date)
 (Nurse's signature) (Provider's signature)