Label

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)

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

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

List hospitalizations, surgeries and dates: _____
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? _____
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
☐	☐	1. Anemia/Sickle Cell Disease or Trait/Blood disorder	9. Hepatitis/Liver problems	☐	☐
☐	☐	2. Heart disease	10. Migraine headaches	☐	☐
☐	☐	3. Diabetes (if postpartum and had GDM, the repeat screening)	11. Cancer	☐	☐
☐	☐	4. Hypertension/High cholesterol	12. Blood clots in legs or lungs	☐	☐
☐	☐	5. Thyroid/Endocrine	13. Mental illness/Emotional disorders	☐	☐
☐	☐	6. Pulmonary Disease	14. Transfusions of blood or blood products	☐	☐
☐	☐	7. Kidney Disease	15. Birth defects/Genetic problems	☐	☐
☐	☐	8. Seizure Disorders	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? _____ Do you have monthly menses ☐ Yes ☐ No
   Flow Description (light, moderate, heavy) _____ Date of last menstrual period _____
   How many days do you bleed? _____
   How often do you have your period? _____ Are you menopausal? ☐ Yes ☐ No
   Any problems with your period? _____
   Were you on birth control pills at conception? ☐ Yes ☐ No
   Current OB/GYN? _____
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? _____
   Have you had: HPV testing? ☐ Yes ☐ No When? _____ Dexa Scan? ☐ Yes ☐ No When? _____
   Colposcopy? ☐ Yes ☐ No When? _____ Colonoscopy? ☐ Yes ☐ No When? _____
   LEEP? ☐ Yes ☐ No When? _____
   Birth Control methods used in the past? _____ Present? _____
   Hormone replacement therapy? ☐ Yes ☐ No

D. OBSTETRICAL HISTORY

1. Total pregnancies _____ # Living _____ # Preterm _____ # Abortion _____ # Miscarriage _____
2. Date of last pregnancy _____

☐ 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)

Are you sexually active? ☐ Yes ☐ No
Insertive: Anal ☐ oral ☐ vaginal ☐ Receptive: Anal ☐ oral ☐ vaginal ☐
Orientation: ☐ Heterosexual ☐ homosexual ☐ Bisexual ☐ Other
Do you have pain with sex? ☐ Yes ☐ No
Have you been abused sexually or emotionally, physically? ☐ Yes ☐ No Have you had a recent change in partner? ☐ Yes ☐ No

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. Do you or your partner use condoms and/or dental dams every time you have vaginal, oral or anal sex? ☐ Yes ☐ No
7. Have you ever had an STD? ☐ Yes ☐ No If yes, which STD and when? _____
8. 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? _____
9. Have you or any of your partners ever injected drugs? ☐ Yes ☐ No
10. Have you or any of your partners exchanged money or drugs for sex? _____
11. Have you had a HIV test? ☐ Yes ☐ No If so, when? _____
12. Do you wish to have a HIV test today? ☐ Yes ☐ No

RISK FACTORS:

Do you have unprotected sex? ☐ Yes ☐ No Do you have sex with multiple partners? ☐ Yes ☐ No Occupational? ☐ Yes ☐ No
Drink alcohol, illicit drug use? ☐ Yes ☐ No Community with high prevalence of STDs? ☐ Yes ☐ No
History of STIs? ☐ Yes ☐ No Was your birth mother infected? ☐ Yes ☐ No Early onset of sexual activity? ☐ Yes ☐ No

F. SOCIAL/ENVIRONMENTAL HISTORY

1. Do you smoke, use smokeless tobacco or use electronic nicotine devices?
   ☐ Yes ☐ No If yes, how much? _____ How long? _____ What? _____
2. Drink alcohol? ☐ Yes ☐ No If yes, how much? _____ How long? _____ What? _____
3. Take street drugs? ☐ Yes ☐ No If yes, how much? _____ How long? _____ What? _____
   What type of street drugs? _____
4. Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or 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

Have you ever had counseling? ☐ Yes ☐ No If yes, where? _____
Have you been on medication in the past? ☐ Yes ☐ No
Were you given Daymark information? ☐ Yes ☐ No

Interviewer's Signature: _____ Date: _____

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

H. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = UP-TO-DATE; REF = referred, and NA = not applicable)

Td/Tdap ☐ UTD ☐ REF ☐ NA	MMR ☐ UTD ☐ REF ☐ NA	Varicella ☐ UTD ☐ REF ☐ NA	HPV ☐ UTD ☐ REF ☐ NA	Hepatitis A ☐ UTD ☐ REF ☐ NA
Hepatitis B ☐ UTD ☐ REF ☐ NA	Meningococcal ☐ UTD ☐ REF ☐ NA	Pneumonia ☐ UTD ☐ REF ☐ NA	Influenza ☐ UTD ☐ REF ☐ NA	

Source of Information: ☐ NCIR ☐ Patient ☐ Other Written Documentation

FOR STAFF USE ONLY

SMOKING: ☐ Would Quit
Cessation Counseling ☐
Refer to stop smoking clinic ☐
Smoking cessation assistance (quit paper?) ☐
Negotiate day of cessation ☐
Referral to cessation counselor advisor ☐
Seen smoking by cessation counselor ☐
Smoking cessation program start date _____

ALCOHOL:
Status: Social Drinker
Beer
Liquor
Wine
N/A