ALLEGANY COUNTY DEPARTMENT OF HEALTH REPRODUCTIVE HEALTH SERVICES
INITIAL & ANNUAL FEMALE HISTORY

NAME:_____DATE:_____ID#_____

MEDICAL HISTORY/GYNECOLOGY HISTORY

Do you have OR have you ever had any of the following: (# amount if pertains)

	YES	NO		YES	NO		YES	NO
Seizure Disorder			Pregnancies (#)			Genetic Condition		
Stroke			Births(#)			HIV Disease		
HTN (hypertension)			Abnormal Pap			Hepatitis Disease		
Heart Disease			Colposcopy			Blood (Product)Transfusion		
Rheumatic Fever			Uterine Fibroids			Blood (Product) Exposure		
High Cholesterol			Ovary Disease			DES Exposure		
Varicose Veins			Genital Warts			Drug Use(including injectable)		
Diabetes			Herpes			Alcohol Use		
Gallbladder Problems			Gonorrhea			Tobacco Use (cig, chew,vape, eCig)		
Liver Disease			Chlamydia			Tattoos		
Kidney Disease			Syphilis			Body Piercing(s)		
Thyroid Disease			PID			**IMMUNIZATIONS:**		
Respiratory Disease			Vaginitis			Gardasil (HPV) Vaccine		
Breast Disease			Anemia			Hepatitis B Vaccine		
Cancer			Blood Clots			Hepatitis A Vaccine		
Eye Problems			Depression			MMR Vaccine		
Skin Problems			Migraine Headaches			Tdap Vaccine		
Physical Disability			Mammograms			Varicella Vaccine		
Developmental Disability			Practice Self Breast Exams			Influenza Vaccine		

MENSTRUAL, SEXUAL, & SOCIAL HISTORY:	
Do you use condoms/dental dams? □Yes □No	1st day of last period:
Do you have children now? □Yes □No	Age @ 1st menses:
Do you want to have (more) children? □Yes □No (# yrs apart):	# of days you flow:
Age @ 1st intercourse:	Do you get a period every month? □Yes □No
Date of last intercourse:	Spotting between periods? □Yes □No
Pain/bleeding with intercourse? □Yes □No	Clotting? □Yes □No
Pain with menses? □None □Mild □Moderate □Severe	Current Contraceptive Method:
Total # of sexual partners in your lifetime:	
Who do you have sex with? □Men □Women □Both	Who do you live with:
Type of sex you engage in? □Vaginal □Anal □Oral	Is your family supportive? □Yes □No
Do you have any ALLERGIES? (if yes, list):	
DOMESTIC VIOLENCE SCREEN:	
In the last year have you been hit, slapped, kicked, or physically hurt by a partner or significant other? □Yes □No	
Have you ever been, or are you now, a victim of domestic violence or sexual abuse? □Yes □No	
Are you in a relationship with someone who threatens or physically harms you? □Yes □No	
Has anyone forced you to engage in sexual activities that made you feel uncomfortable? □Yes □No	

I have completed the above information, which is true and accurate to the best of my knowledge. I also acknowledge that the information is provided for the sole purpose of assisting the staff to provide me with adequate care and that all information provided is strictly confidential and cannot be shared without written consent by myself.

CLIENT SIGNATURE:_____DATE:_____

STAFF SIGNATURE & TITLE:_____DATE:_____