MEDICAL CONDITIONS (CURRENT & PAST)

- **ADD/ADHD**: □ Yes □ No
- **High Cholesterol**: □ Yes □ No
- **Anxiety**: □ Yes □ No
- **Kidney Disease**: □ Yes □ No
- **Blood Clots**: □ Yes □ No
- **Liver Disease, Hepatitis or Tumor**: □ Yes □ No
- **Bleeding Disorder**: □ Yes □ No
- **Migraine Headache**: □ Yes □ No
- **Depression**: □ Yes □ No
- **Diabetes**: □ Type I □ Type II
- **Seizures**: □ Yes □ No
- **Anorexia**: □ Yes □ No
- **Blood Clot or other clotting disorder**: □ Yes □ No
- **High Blood Pressure**: □ Yes □ No
- **UTI (frequent)**: □ Yes □ No
- **Stroke or Stroke-like Problems**: □ Yes □ No

ALLERGIES

- **Allergies/Intolerance to medications**: Medication | Reaction(s)
- **Allergies to Food/Insects/Latex**: Substance | Reaction(s)

SURGICAL HISTORY

- **Date**: Operation | Hospital

HOSPITALIZATIONS

- **Date**: Reason | Hospital

FAMILY HISTORY

Do you have a parent, brother or sister with a history of the following: (if so, please list relation)

□ **No known Medical problems in family**

<table>
<thead>
<tr>
<th>Relation</th>
<th>Relation</th>
<th>Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anxiety</strong></td>
<td>□ Heart attack before age 65 in a female</td>
<td>□ Other cancer</td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
<td>□ Heart attack before age 55 in a male</td>
<td>□ Stroke</td>
</tr>
<tr>
<td><strong>Bleeding</strong></td>
<td>□ High blood pressure</td>
<td>□ Thyroid Disease</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td>□ High cholesterol</td>
<td>□ Blood Clot or other clotting disorder</td>
</tr>
<tr>
<td><strong>Diabetes Type II</strong></td>
<td>□ Skin cancer</td>
<td>□ Other</td>
</tr>
</tbody>
</table>
### SOCIAL HISTORY

**Do you drink alcohol?**
- ☐ No
- If no, skip next section

How often do you have a drink containing alcohol?
- ☐ Never
- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

How many drinks do you typically have when drinking?
- ☐ 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

How often do you have six or more drinks on one occasion?
- ☐ Never
- ☐ Monthly or less
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Has alcohol ever affected your sexual health?
- ☐ Yes
- ☐ No
- ☐ Have you ever experienced a blackout due to alcohol?
- ☐ Yes
- ☐ No

**Do you use tobacco?**
- ☐ No
- If no, skip next section

□ Yes # of Years
□ Cigarettes – #/day
□ Chew - #/day
□ Vaping - #/day
□ Cigars - #/day

**Do you use recreational drugs?**
□ No (If no, skip this section)
□ Marijuana
□ Cocaine
□ Stimulants
□ Ecstasy
□ Opiate Pain Medication (Percocet, Oxy)
□ Heroin
□ Hallucinogens (LSD, Mushrooms, PCP)
□ Other :

Do you exercise regularly?
□ No
□ Yes
□ Any limiting factors?
□ No
□ Yes – Explain:

Activities:

Days per week:
□ 1-2
□ 3-4
□ 5
□ 6
□ 7

Duration (minutes):
□ <15
□ 15-30
□ 30-45
□ 45-60
□ >60

Exertion:
□ Mild
□ Moderate
□ Heavy

### REVIEW OF SYSTEMS (CHECK CURRENT SYMPTOMS ONLY)

<table>
<thead>
<tr>
<th>General:</th>
<th>Gastroenterology:</th>
<th>Neuro:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Fatigue</td>
<td>☐ Nausea</td>
<td>☐ Headache</td>
</tr>
<tr>
<td>☐ Fever</td>
<td>☐ Vomit</td>
<td>☐ Numbness</td>
</tr>
<tr>
<td>☐ Chills</td>
<td>☐ Diarrhea</td>
<td>☐ Tingling</td>
</tr>
<tr>
<td>☐ Weakness</td>
<td>☐ Constipation</td>
<td>☐ Spinning sensation</td>
</tr>
<tr>
<td>☐ Weight Changes</td>
<td>☐ Blood in stool</td>
<td>☐ Seizure</td>
</tr>
<tr>
<td>☐ Night Sweats</td>
<td>☐ Abdominal Pain</td>
<td>☐ Loss of consciousness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart:</th>
<th>Breast:</th>
<th>Psych:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Chest Pain</td>
<td>☐ Nipple discharge</td>
<td>☐ Depressed/Low mood</td>
</tr>
<tr>
<td>☐ Irregular heartbeat</td>
<td>☐ Pain</td>
<td>☐ Anxiety</td>
</tr>
<tr>
<td>☐ Shortness or tightness of breath</td>
<td>☐ Lump</td>
<td></td>
</tr>
<tr>
<td>☐ Lightheaded</td>
<td>☐ Skin changes</td>
<td></td>
</tr>
<tr>
<td>☐ Leg swelling</td>
<td>☐ Fainting</td>
<td></td>
</tr>
<tr>
<td>☐ Fainting</td>
<td>☐ Memory Loss</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin:</th>
<th>Genital:</th>
<th>Respiratory:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Rash</td>
<td>☐ Unusual vaginal bleeding</td>
<td>☐ Wheezing</td>
</tr>
<tr>
<td></td>
<td>☐ Unusual vaginal discharge</td>
<td>☐ Chest tightness</td>
</tr>
<tr>
<td>☐ Change in mole</td>
<td>☐ Problems with orgasm</td>
<td>☐ Difficulty breathing</td>
</tr>
<tr>
<td>☐ Lump</td>
<td>☐ Painful sex or sexual problems</td>
<td></td>
</tr>
<tr>
<td>☐ Dry skin</td>
<td>☐ Unusual bumps or sores</td>
<td></td>
</tr>
<tr>
<td>☐ Itching</td>
<td>☐ problem with erections</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endocrine:</th>
<th>Blood/Lymphatic:</th>
<th>Muscle:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Cold tolerance</td>
<td>☐ Excessive bleeding</td>
<td>☐ Joint pain</td>
</tr>
<tr>
<td>☐ Heat tolerance</td>
<td>☐ Swollen lymph nodes</td>
<td>☐ Bruising</td>
</tr>
<tr>
<td>☐ Increased thirst</td>
<td></td>
<td>☐ Muscle pain</td>
</tr>
<tr>
<td>☐ Increased urination</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ears/Nose/Throat:</th>
<th>Eyes:</th>
<th>Allergy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Ear pain</td>
<td>☐ Decreased vision</td>
<td>☐ Runny nose</td>
</tr>
<tr>
<td>☐ Ringing</td>
<td>☐ Double vision</td>
<td>☐ Itchy eyes</td>
</tr>
<tr>
<td>☐ Hearing changes</td>
<td>☐ Eye pain</td>
<td>☐ Sneezing</td>
</tr>
<tr>
<td>☐ Congestion</td>
<td>☐ Light sensitive</td>
<td>☐ Food allergy</td>
</tr>
<tr>
<td>☐ Trouble swallowing</td>
<td></td>
<td>☐ Insect Allergy</td>
</tr>
<tr>
<td>☐ Hoarseness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Urinary: | | |
|----------| | |
| ☐ Urinating frequently | | |
| ☐ Urgency | | |
| ☐ Pain when urinating | | |
| ☐ Blood in urine | | |
| ☐ Leaking urine | | |
### PLEASE COMPLETE ALL THE SECTIONS THAT APPLY TO YOU

#### RELATIONSHIP STATUS
- [ ] Single  [ ] Partnered  [ ] Married  [ ] Separated  [ ] Divorced  [ ] Widowed

Do you feel safe with your partner?
- [ ] No  [ ] Yes

Have you experienced unwanted sexual activity as a child or as an adult?
- [ ] No  [ ] Yes

Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?
- [ ] No  [ ] Yes

#### SEXUAL HISTORY

**Sexual Identity:**
- [ ] Heterosexual  [ ] Lesbian  [ ] Gay  [ ] Bisexual  [ ] Queer  [ ] Unsure  [ ] Other

Have you engaged in sexual contact with:
- [ ] Men  [ ] Women  [ ] Both  [ ] Neither  [ ] N/A (skip section)

**SEXUAL ACTIVITY**

If yes, please mark sexual activity type:
- [ ] Oral sex  [ ] Vaginal intercourse  [ ] Anal receptive  [ ] Anal penetrative

Age at first intercourse  Number of sexual partners/contact in the last year

How often do you use condoms/barriers/dam when having anal sex:
- [ ] All  [ ] Most  [ ] Some  [ ] Never  [ ] N/A

How often do you use condoms/barriers/dam when having vaginal sex:
- [ ] All  [ ] Most  [ ] Some  [ ] Never  [ ] N/A

How often do you use condoms/barriers/dam when having oral sex:
- [ ] All  [ ] Most  [ ] Some  [ ] Never  [ ] N/A

**SEXUALLY TRANSMITTED INFECTION HISTORY**

Have you ever been tested for Sexually Transmitted Infections (STI's)?
- [ ] No  [ ] Yes  [ ] N/A

Have you ended or started sexual contact since your last STI testing?
- [ ] No  [ ] Yes

Do you want STI testing today?
- [ ] No  [ ] Yes

Have you ever been diagnosed with or treated for any of the following:
- [ ] Chlamydia  [ ] Hepatitis B  [ ] Genital Herpes  [ ] Syphilis  [ ] Oral Herpes  [ ] Gonorrhea  [ ] HPV (genital warts)  [ ] Other

Have you discussed Sexually Transmitted Infections (STI) risk with contacts/partners?
- [ ] No  [ ] Yes

**VACCINATIONS**

HPV:
- [ ] Started  [ ] Completed 3 shots

**GYNECOLOGY**

Date of last Pap:
- [ ] Normal  [ ] Abnormal  Results:

Have you ever had an abnormal pap?
- [ ] Yes  [ ] No  Dates:  Results:

Have you had Colposcopy?
- [ ] Yes  [ ] No  Dates:  Results:  Biopsy Results:

**MENSTRUAL HISTORY**

Age at first period?  Period comes every how many days?  Period usually lasts how many days?

First day of your last period:
- [ ] Yes  [ ] No  Do you spot between periods?

Periods are:
- [ ] Light  [ ] Moderate  [ ] Heavy  [ ] Regular  [ ] Irregular  [ ] Painful

Do you take medication for PMS or menstrual cramps or cycle regulation?
- [ ] Over the counter  [ ] Prescription

Have you had unprotected sex since your last period?
- [ ] No  [ ] Yes (Dates):

**CONTRACEPTIVE HISTORY**

Pregnancy prevention is not needed because?

Current pregnancy prevention method?

How long used?

What pregnancy prevention method do you want to use now?

What pregnancy prevention method have you used in the past?

Note any problems with that method:

**PREGNANCY HISTORY**

- [ ] Not Applicable (skip section)  [ ] Never Pregnant  [ ] Currently Pregnant  [ ] Currently breastfeeding

Have you ever been pregnant?
- [ ] Yes  [ ] No  [ ] Unsure

If yes, what was the outcome?
- [ ] birth # ______  [ ] abortion # ______  [ ] miscarriage # ______  [ ] ectopic pregnancies # ______

Complications or comments:

Thank you for taking the time to complete this form. The information will help us to better take care of you while you are here at UNCI!