INTERIM HEALTH HISTORY
DATE:

Name (Last, First, MI.):

Preferred Name:	**Preferred Pronoun:**
PID:	**Date of Birth:**

Reason for Visit:

CURRENT MEDICATIONS

Name the Medication	Dosage	Frequency Taken
Do you need a medication refill today?		

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

Year quit ☐ Have you quit more than once | Planning to quit: ☐ now ☐ considering quitting ☐ no plan to quit

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 :

EXERCISE

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

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
Total lifetime partners	Are you in a mutually monogamous relationship? For how long?

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	☐ Oral Herpes	☐ Gonorrhea
	☐ Genital Herpes	☐ Syphilis	☐ HPV (genital warts)	☐ Other
Have you discussed Sexually Transmitted Infections (STI) risk with contacts/partners?	☐ No	☐ Yes		

VACCINATIONS

HPV: ☐ Started ☐ Completed 3 shots