

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