

INITIAL HEALTH HISTORY (update every 3 years)

Today's Date: _____

Wellness Center of Door County, Inc
PO Box 85, Sturgeon Bay, WI 54235

Patient Name _____ AGE: _____ Date of Birth: _____ Chart # _____

Reason for visit today: regulation of my period/cycle severe cramping with my period birth control annual exam vaginal infection morning after pill pregnancy test
 unusual bleeding no period(s) STD/HIV testing menopause symptoms bladder symptoms/infection other: _____

List medical care in the past year: _____

Are you currently being treated for any health condition? No Yes depression anxiety other _____

Who is your medical provider (MD, Nurse Practitioner, etc)/ clinic? _____

Allergies: latex penicillin/amoxicillin sulfa codeine morphine anesthesia aspirin other: _____ NO KNOWN DRUG ALLERGIES

List current medications, vitamins, over the counter medications and/or herbs you regularly take/use: _____

Black cohosh Remifemin / Estroven Vitamin- _____ Aspirin/Tylenol Calcium Ibuprofen Midol/Pamprin NuvaRing Patch Depoprovera Pill:

PAST MEDICAL HISTORY		Yes	No	Staff			Yes	No	Staff
<i>General:</i>					<i>Gastrointestinal/Endocrine:</i>				
1. My health is generally good					24. Stomach/bowel problems				
2. Any <i>serious</i> illnesses/injuries/surgeries or hospitalizations?					25. Liver disease/jaundice				
3. Recent weight gain or loss?					26. Hepatitis/mono				
4. Cancer					27. Gallbladder problems				
5. Genetic conditions or birth defects					28. Diabetes				
6. Vaccine for Rubella (German measles)					<i>Neurological:</i>				
7. Vaccine for tetanus last date: _____					29. Migraines/SEVERE headaches				
8. Vaccine for Hepatitis B / date: _____					30. Numbness, sensory loss				
<i>Eyes, Ears, Nose, Throat:</i>					<i>Psychological:</i>				
9. Blurred, double or loss of vision					32. Depression requiring treatment / hospitalization				
10. Thyroid problems					33. Other mental health issues or eating disorders				
11. Frequent sore throats					<i>Genitourinary:</i>				
<i>Cardiovascular:</i>					34. Breast lump, discharge or surgery				
12. Blood clotting disorder					35. Last Pap test date: ___/___/___				
13. Anemia					36. Abnormal Pap tests				
14. Sickle cell anemia/trait					37. Colposcopy / cryotherapy / LEEP				
15. Blood clots in veins or lungs					38. Uterine or ovarian growths or abnormalities				
16. Mitral Valve Prolapse					39. Pelvic infection/PID				
17. Stroke					40. Abdominal or pelvic pain				
18. High blood pressure					41. Pain/bleeding with sexual intercourse				
19. Heart disease or murmurs					42. Bladder/kidney problems				
20. High cholesterol					43. Current pain/burning or frequent urination				
<i>Respiratory:</i>					44. Leakage of urine				
21. Severe chest pain / shortness of breath					45. Recurrent vaginal infections				
22. Tuberculosis					46. Current vaginal discharge, odor, itching, bumps/ sores				
23. Chronic cough / asthma					47. Uterus Removed/Hysterectomy?				

FAMILY HISTORY		Yes	No	Who?	MENSTRUAL HISTORY		
Are you adopted?					When was the first day of your last period? _____		
Did your mother take DES while she was pregnant with you? (answer if born before '71)					It seemed normal _____ not normal _____		
Age/Mom: _____ Age/Dad: _____					Age when period started _____		
Does your Mother (M), Father (F), Brother (B) or Sister (S) have any of these:					My periods are usually <input type="checkbox"/> regular <input type="checkbox"/> irregular		
Increased cholesterol					My periods come every _____ days & last _____ days		
Diabetes					My flow is _____ light _____ medium _____ heavy		
Increased blood pressure					Yes	No	Comments
Cancer (type) _____					Ever been told you'd have trouble getting pregnant?		
Depression					Are you bleeding today?		
Heart attack before 55 years old					Any vaginal bleeding after sex?		
Thyroid Disorder					Any vaginal bleeding between periods?		
Alcohol/Drug Abuse or Recovery					Would you like to decrease or stop your cramps?		
Number of Biological Siblings: S- _____ B- _____					Would you like to decrease the frequency of your period?		
PREGNANCY HISTORY (check appropriate boxes) Never pregnant # Times Pregnant					Would you like to eliminate your period if it is safe to do?		
Year	Vaginal	C Section	Miscarriage	Adopted	Abortion		
Any problems (i.e. diabetes, genetic abnormalities, still births, edema)? No <input type="checkbox"/> Yes <input type="checkbox"/>					Problems with your periods? (heavy flow, fatigue, cramps)		
please explain:					Have you stopped having periods? Year: _____		

Staff Comments: _____

11/04 OVER →

CONTRACEPTIVE HISTORY (please fill in and check appropriate answers)

	Yes	No	Comments
Current method of birth control _____ How long? _____ Any problems with this method?			
If you want a method today, what is it? _____			
What methods have you used in the past? <input type="checkbox"/> condoms <input type="checkbox"/> rhythm <input type="checkbox"/> pills <input type="checkbox"/> shot <input type="checkbox"/> pulling out <input type="checkbox"/> patch <input type="checkbox"/> ring <input type="checkbox"/> IUD <input type="checkbox"/> tubes tied <input type="checkbox"/> vasectomy			
Any problems with those methods? <input type="checkbox"/> forgetting to take <input type="checkbox"/> patch sticking <input type="checkbox"/> nausea <input type="checkbox"/> change in sex drive other: _____			
Have you had sex without a birth control method since your last period? DATE: _____			
Are you concerned that you might be pregnant?			
Are you planning a pregnancy in the next year?			

SOCIAL HISTORY (please fill in and check the appropriate answers)

General:	Yes	No	Staff Comments
1. Have you ever been emotionally abused?			
2. Do you have a history of sexual abuse, being raped or molested?			
3. Do you feel threatened by or afraid of someone?			
Lifestyle:			
4. Do you smoke / use tobacco products? If yes: # cigarettes/day _____ If yes, would you like help with becoming a non-smoker?			
5. Do you now or have you in the past used alcohol regularly?			
6. If you currently use alcohol how much & how often ?			
7. Do you now or have you in the past used street drugs? If yes, select all that apply: <input type="checkbox"/> weed <input type="checkbox"/> cocaine <input type="checkbox"/> crack <input type="checkbox"/> ecstasy <input type="checkbox"/> psychedelics <input type="checkbox"/> amphetamines <input type="checkbox"/> narcotics <input type="checkbox"/> hash <input type="checkbox"/> other _____			
8. Have you had a blood transfusion since 1978?			
9. Do alcohol or drugs cause problems in your life?			
10. Do you feel rested when you wake up in the morning?			
11. Do you have difficulty falling or staying asleep?			
12. Have you lost interest in the things that normally give you pleasure?			
13. Have you had or currently have any thoughts of suicide?			
Exercise/Purposeful Activity:			
14. Excluding your job do you do any purposeful exercise?			
15. If yes select type <input type="checkbox"/> walk <input type="checkbox"/> run <input type="checkbox"/> pilates <input type="checkbox"/> dance <input type="checkbox"/> weights <input type="checkbox"/> yoga <input type="checkbox"/> bike <input type="checkbox"/> swim Frequency/duration per week: _____			
16. If no what gets in your way? <input type="checkbox"/> time <input type="checkbox"/> \$ <input type="checkbox"/> no motivation <input type="checkbox"/> weather <input type="checkbox"/> I can't find something I enjoy doing <input type="checkbox"/> see no benefit			
Dietary:			
17. How many servings a day do you eat or drink of the following: <input type="checkbox"/> 8 oz milk <input type="checkbox"/> 1/2 C cottage cheese <input type="checkbox"/> 1.5 oz cheese <input type="checkbox"/> 8 oz yogurt <input type="checkbox"/> regular soda <input type="checkbox"/> diet soda <input type="checkbox"/> regular coffee/tea			
18. Do you take a multivitamin EVERY DAY?			
19. Do you take a calcium supplement (chew or pill, etc)			
20. How do you feel about your weight now? _____			
Sexual:			
21. Are you/have you been sexually active? (including ORAL sex) If yes, with (check all that apply): <input type="checkbox"/> men <input type="checkbox"/> women <input type="checkbox"/> both <input type="checkbox"/> anal <input type="checkbox"/> oral <input type="checkbox"/> vaginal			
22. Are you in a current sexual relationship?			
23. Have you or your partner(s) had a new partner or more than one partner in the last 90 days?			
24. Have you or your partner(s) had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days?			
25. Have you had chlamydia in the last 5 years?			
26. Have you been diagnosed with chlamydia, gonorrhea or pelvic inflammatory disease in the last 2 years?			
27. Are you or your partner infected with HIV?			
28. Does your partner(s) now or has your partner in the past injected drugs?			
29. Is your partner bisexual (has/had sex with both males and females) ?			
30. Are you having sex with condoms ALL THE TIME? (including with oral)			
31. Number of sex partners in the last year: _____ lifetime: _____			
32. Age of first intercourse? _____ not applicable			
33. Have you ever had any of the following: HPV / Genital warts / Herpes / Molluscum Syphilis / Gonorrhea (circle all that apply)			
34. Do you have any questions about your sexuality?			
35. Do you have any hot flashes, night sweats or mood changes?			
36. Do you have any problems with vaginal dryness?			

To the best of my knowledge, the above information is complete and accurate.

Patient signature: _____ Date: _____

Staff signature: _____ Date: _____