## 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? □ condoms □ rhythm □ **pills** □ shot □ pulling out □ patch □ ring □ IUD □ tubes tied □ vasectomy | | | |
| Any problems with those methods? | | | |
| Have you had sex without a birth control method since your last period? | | | |
| 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: __weed __cocaine __ crack __ ecstasy | | | |
| __ psychedelics __amphetamines __ narcotics __hash __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 __walk __ run __ pilates __dance __weights __ yoga | | | |
| __ bike __swim Frequency/duration per week: ______________ | | | |
| 16. If no what gets in your way? __ time __ $ ___ no motivation | | | |
| __ weather ___ I can't find something I enjoy doing ___ see no benefit | | | |
| *Dietary:* | | | |
| 17. How many servings a day do you eat or drink of the following: | | | |
| _____ 8 oz milk ____ 1/2 C cottage cheese _____ 1.5 oz cheese | | | |
| _____ 8 oz yogurt ____ regular soda ___ diet soda ___ 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):* | | | |
| ___ men ___ women ___ both ___ anal ___oral ___ vaginal | | | |
| 22. Are you in a current sexual relationship? | | | length of time_________ |
| 23. Have you/your partner(s) had one or more new partner(s) in the past year? | | | |
| If yes are you having sex with condoms ALL THE TIME? | | | |
| 24. Have you ever had any of the following:: (circle those which apply) | | | |
| Chlamydia/ HPV / Genital warts / Herpes / Syphillis / Gonorrhea | | | |
| 25. Do you have any hot flashes, night sweats or mood changes? | | | |
| 26. Have you tried any herbs/over the counter products? | | | |
| 27. Are you experiencing any vaginal dryness? | | | |
| If yes---how do you manage? | | | |
| 28. Are you having any pain in your vulva (vaginal lips) or vagina ? | | | |
| 29. Have you lost your interest in sex recently? | | | |
| 30. How do you feel about your sexual relationship? | | | |
| *Mid-Life Health Maintenance* | | | |
| 31. Have you begun having mammorgrams? | | | Year: _______ Location: |
| 32. How often do you do a breast self exam? | | | |
| 33. Have you had a colonoscopy? | | | Year:________ |
| 34. Have you had a bone density test (DEXA SCAN)? | | | Year:________ |
| 35. Have you had any fractures in the past 5 years? | | | |
| 36. Any issues you want to discuss? Please list: | | | |

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

Patient signature:__________________________________________________Date:____________________

Staff signature:___________________________________________________Date:____________________