FAMILY Circle of Care

What is the reason for your visit today?

_____

_____

_____

PERSONAL MEDICAL HISTORY

Have **YOU** ever had any of these problems – **now or in the past**? (*Please circle*)

Abnormal Pap smear	Asthma	Liver disease	Fibroids
HPV infection (human papilloma virus)	Hypertension / high blood pressure	Migraine headaches	Polycystic ovarian syndrome (PCOS)
Gonorrhea	Born with heart problems (congenital heart disease)	Blood clot in leg or lung (DVT or PE)	Cancer of the Breast
Chlamydia	Heart attack/ coronary artery disease	Problem with blood system: sickle cell anemia or trait	Cancer of the Uterus
Trichomonas (Trich)	Diabetes only in pregnancy	Problem with blood system: thalassemia	Cancer of the Colon
HIV / AIDS	Diabetes outside of pregnancy	Thrombophilia (problem that makes you clot)	Cancer of the Ovary
Herpes / cold sores	Lupus/other connective tissue disorder	More than 2 miscarriages	Cancer of the Cervix
Hepatitis	Bladder/kidney infection (UTI)	Blood type RH negative	Other Cancer
Syphilis	Kidney stones	Anemia/low blood count	Infertility
Genital warts	Other kidney disease	Cystic fibrosis or cystic fibrosis carrier	History of trauma or violence
Depression	Anxiety	Thyroid problem (low or high)	Problem with anesthesia
Other mental disorder	TB (tuberculosis)		

Other medical problems you have currently or have had in the past?

_____

_____

_____

What **surgeries** have you had /what year?

C/section	Hysterectomy	Removal of ovaries	Removal or tying of tubes
Gallbladder removal	Appendix removal	Removal of fibroids (myomectomy)	Removal of Tonsils/adenoids

Other Surgeries:

_____

_____

_____

OBGYN

How many pregnancies have you had? _____ How many live births? _____

How many miscarriages or abortions? _____ Any ectopic pregnancies (pregnancy in a tube?) _____

How many children do you have living now?

Please fill in for each pregnancy:

Date:	Birth or pregnancy loss?	Birth type? Vaginal or cesarean section	Complications?

Age at your first period? _____ Do you have periods every month? _____

Date of last period: _____

I identify my gender as: ☐ Female ☐ Male ☐ Trans-female ☐ Trans-male ☐ Other _____

My gender at birth was: ☐ Female ☐ Male

I am attracted to/sexually active with partners who are

☐ Female ☐ Male ☐ Trans-female ☐ Trans-male Other _____

When would you like to have a pregnancy? _____

Are you currently using anything to prevent pregnancy? If so, what? _____

_____

Do you smoke? ☐ No ☐ Yes, How much/how often? _____

Do you drink alcohol? ☐ No ☐ Yes, How much/ how often? _____

Do you use any street drugs? ☐ No ☐ Yes, How much/ how often?

Are you experiencing social circumstances that could affect your health or safety such as unstable housing situation, not having enough food, job insecurity, personal violence or abuse?

☐ No ☐ Yes ☐ Prefer to discuss in person

Please explain:

_____

_____

Allergies:

☐ No known drug/food/environmental allergies

Allergic to/Reaction:

_____

_____

Current medications/supplement you take: ☐ No current medications

_____

_____

_____

Family History:

What diseases run in your family? Please circle and write which family members.

Diabetes	High blood pressure	Clot in leg or lung	Stroke
Thyroid problems	Liver problems	Kidney problems	Autoimmune problems

Cancer? What kind? _____

Other: _____

_____

Health Care Maintenance:

Do you have a primary care doctor? ☐ No ☐ Yes Who? _____

Have you had a mammogram before? ☐ No ☐ Yes Where/When?

Have you had a pap smear before? ☐ No ☐ Yes Where/When?

Have you had colon cancer screening before? ☐ No ☐ Yes Where/When?

Teenagers only:

We encourage family participation with your reproductive health care, but understand that at times you may desire a visit that is confidential from your parents/guardians. Certain things require us to break confidentiality exist – specifically concerns regarding abuse, thoughts of self-harm or harm to others.

Do you request your visit today be confidential from your parents/guardians? ☐ NO ☐ YES