**Patient Label Here:**

* If you are unsure of any question, leave blank and ask the nurse for help.

### Medical History:
Circle those that apply, Y for yes or N for no.  

<table>
<thead>
<tr>
<th>Condition</th>
<th>You</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lupus</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Seizures or Stroke</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Sickle Cell Anemia or Trait</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Blood Clots in legs or lungs</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Heart Disease/Defect or Murmur</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Bleeding Disorder/Hemophilia</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Asthma or Chronic Bronchitis</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Liver Disease/Hepatitis</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Gallbladder Disease/Gallstones</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Stomach Problems/Ulcers</td>
<td>Y or N</td>
<td>Y or N</td>
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<tr>
<td>Bowel Problems</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Kidney/Bladder Problems</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>Cancer</td>
<td>Y or N</td>
<td>Y or N</td>
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<tr>
<td>Diabetes/Sugar Problems</td>
<td>Y or N</td>
<td>Y or N</td>
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<tr>
<td>Scoliosis</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Severe headaches/migraines</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Skin rashes, sores or moles</td>
<td>Y or N</td>
<td></td>
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<tr>
<td>Tattoos or Piercing</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Anemia (low blood/low iron)</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Depression/Anxiety/Eating Disorders</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Bi-polar Disorder/Schizophrenia</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Drink Alcohol</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Smokes/Chews/Dips Tobacco</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Use Street Drugs</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td>Diet Supplements/Herbal Medications</td>
<td>Y or N</td>
<td></td>
</tr>
</tbody>
</table>

### Nursing Comments:

### Have you ever had a major illness? Please explain:

### Have you ever been in the hospital? If so why:

### Have you ever had any type of surgery?

### List all medications you are taking:

### Tuberculosis Risk Assessment Questionnaire:
Is the child a close contact of a person with infectious TB?  
Does the child have HIV infection or is he/she considered at risk for HIV infection?  
Is the child foreign born (especially Asian, African, Latino) a refugee or immigrant?  
Is the child in contact with an incarcerated person or a person was incarcerated in the past 5 years?  
Does the child have a medical condition or treatment of a medical condition which suppresses the immune system?  
Does the child live in a community in which it has been established that a high risk exists for TB?  
Does the child have a history of travel or contact with an individual who traveled to endemic countries?

D4 8/2008
**WOMEN ONLY:**

**Menstrual/ Gynecological History**

What age did your menstrual periods begin? ______________

When did your last period start? ______________

How many days did it last? ______________

Was it normal? Yes ___ No ___ Explain ______________

How often do you have your periods? ______________

Any problems? ______________

Do you douche? Yes ___ No ___

Do you have a vaginal discharge/odor? Yes ___ No ___

Do you examine your breasts? Yes ___ No ___

If yes how often? ______________

Any Breast problems? ______________

Have you ever had a pelvic exam? Yes ___ No ___

If yes, date of last pelvic exam? ______________

Date of your last Pap Smear? ______________

Have you ever had an Abnormal Pap? Yes ___ No ___

Have you ever had a Mamogram? Yes ___ No ___

If yes, date of last Mamogram? ______________

**SEXUAL & CONTRACEPTIVE HISTORY:**

Age at first intercourse? ______________

Date of last intercourse? ______________

Number of current partners? ______________

How many sexual partners have you had? ______________

Do you use condoms every time you have sex? Yes ___ No ___

Do you have sex with:

Men Only: _____ Women Only: _____ Both Men & Women: _____

Do you have pain or bleeding with sex? Yes ___ No ___

Do you inject any drugs? Yes ___ No ___

Do you or your partner have HIV or AIDS? Yes ___ No ___

Check the ways you have sex:

Vaginal ____ Oral ____ Anal _____

Have you had recent chills or fever? Yes ___ No ___

Have you or your partner ever had a sexually transmitted disease? If yes, please circle which STD(s)?

(Gonorrhea, Chlamydia, Syphilis, Herpes, HPV, Other)?

What do you use for birth control?

Pills ____ Depo ____ Foam/Gel ____ Diaphragm ____

IUD ____ Patch ____ Condoms ____ Abstain ____

Withdrawal/Pull Out ____ None _____

Are you satisfied with the method? Yes ____ No ____

If no, what method(s) do you wish?

Do you or your partner want to become pregnant? Yes ____ No ____

If yes, when? ______________

**MEN ONLY:**

Have you been circumcised? Yes ___ No ___

Do you have any problems with testicles or scrotum (Lumps, Pain, Swelling)? Yes ___ No ___

Do you perform testicular self-exams? Yes ___ No ___

Have you ever been involved in a pregnancy or fathered a child? Yes ___ No ___

**RELATIONSHIPS:**

Have you ever been hit, kicked, shoved, or had things thrown at you by your partner? Yes ___ No ___

Have you ever been forced by anyone to have intercourse or any form of sexual contact against your will (when you have said or wanted to say "NO") Yes ___ No ___

Have you or your children ever been afraid/threatened by your partner/boyfriend? Yes ___ No ___

Is there any close friend or family member that you can talk to about sex, or other sensitive matter? Yes ___ No ___

If yes, whom? ______________

Do you ever feel like hurting yourself? Yes ___ No ___

**PROVIDER/NURSE COMMENTS ONLY:**

_________________________ ___________________________

Client’s Signature/ Legal Guardian: ____________________________ Date: ______________

Interpreted By: ____________________________ Date: ______________

Reviewed By: ____________________________ Date: ______________

Confidential Client (CIRCLE) Yes ___ No ___