

This medical record is *confidential* and will not be released to anyone except as may be required by law.

St. Croix County DHHS-Public Health Dept.

Date _____

Reproductive Health

1752 Dorset Lane, New Richmond, WI 54017

Chart # _____

715-246-8365 Fax 715-246-8298

FEMALE MEDICAL HEALTH HISTORY

Name _____ Date of Birth ____/____/____ Age _____
Last First M

Reason for visit: _____

Please check if you are allergic to: **No Allergies**
Penicillin Iodine Zithromax Doxycycline Sulfa Metal Rocephin
Tetracycline Latex Local anesthetic Amoxicillin Other _____

List medications, vitamins, over-the-counter drugs, and/or herbs you take: _____

Have you recently taken antibiotics? Yes No If yes, when _____ for what _____ what kind _____

MENSTRUAL HISTORY

First day last period: _____ Was it normal? Yes No
Do you have bad cramps? Yes No
Do you bleed heavy? Yes No
Have you had sex since your period? Yes No
Age of first period: _____

SEXUAL HISTORY

Have you ever had sex? Yes No (If no, go to next section.) Age of first intercourse: _____
Have you had more than one sexual partner in your lifetime? Yes No
Have you had a new sex partner in the last 90 days? Yes No
Has your partner had a different sex partner in the last 90 days? Yes No Don't know
Circle if you have: vaginal sex oral sex anal sex sex with men sex with women sex with both
Have you ever had: Chlamydia Gonorrhea HPV/warts Herpes Syphilis
Have you or your partner(s) used IV drugs? Yes No Don't know
Have you had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days? Yes No
Has your partner had symptoms or diagnosis of a sexually transmitted infection in the last 90 days? Yes No Don't know

PREGNANCY (If never been pregnant – go to next section.)

REPRODUCTIVE LIFE PLAN

How many times have you been pregnant? _____ Do you hope to have any (more) children? Yes No
Date(s) when your pregnancy(ies) ended _____ How many children do you hope to have? _____
Are you breastfeeding? Yes No How long do you plan to wait until you (next) become pregnant? _____

What do you plan to do until you are ready to get pregnant? _____

What can I do today to help you achieve your plan? _____

CONTRACEPTIVE HISTORY

Do you ALWAYS use condoms? Yes No
Are you using birth control now? Yes No If yes, what kind _____
Do you want birth control today? Yes No If yes, what kind _____
What kind of birth control have you used in the past? _____
Any problems with those methods? _____

SOCIAL HISTORY

Do you smoke cigarettes Yes No If yes, _____ # per day. Do you want to quit? Yes No
Do you drink alcohol? Yes No Do you use street drugs? Yes No
Does alcohol/drugs cause problems in your life and/or are others concerned? Yes No
Do you feel threatened or afraid of someone in your life? Yes No
Have you ever received medical care/medications for your mental health? Yes No
Circle if have any concerns about: Date rape Forced/unwanted sex Physical abuse Weight

PAST MEDICAL HISTORY

Have you ever been in the hospital? Yes No If yes, why _____
Do you have a doctor? Yes No If yes, doctor's name _____
Date of your last pap smear: _____ What clinic: _____
List any medical problems: _____

