

Health Quarters
Annual Medical History

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I am adopted. ()

Father - Living / Deceased Mother - Living / Deceased (Please circle one)

PCP – Primary Care Physician: _____ **Today's Date:** _____

	NO	YES	COMMENTS
Are you allergic to any medication?			
Are you taking any medication now?			
FAMILY HISTORY			
Since your last visit has anyone in your family had any heart disease, stroke, high blood pressure, high cholesterol, diabetes, cancer or Osteoporosis?			
PERSONAL HISTORY Since your last visit have you:			
Had any serious illness, surgery, or been hospitalized?			
Had anorexia nervosa or bulimia?			
Had any emotional problems?			
Felt unsafe in a relationship due to physical/sexual threats or violence?			
Been forced to have sex or sexual contact when you didn't want to?			
Had sex without condoms or latex barriers?			
OR a partner shared needles (injecting drugs/ tattooing/piercing)?			
Used alcohol or other drugs before having sex?			
Do you smoke cigarettes? (How many per day? _____)			
Do you use alcohol/pot/crack/cocaine/heroin/tranquilizers/ ecstasy? (Please circle)			
Do you currently:			
Feel you eat a well-balanced diet that includes extra calcium & Vitamin D?			
Exercise regularly?			
Do breast self-exams monthly?			
Have you had the HPV vaccine?			
GYN and SEXUAL HISTORY Since your last visit, have you:			
Had an Abnormal Pap Smear?			
Had a STD (Sexually Transmitted disease)?			
Do you think you might be pregnant now?			
Had sex without a birth control method?			
Had a baby / an abortion / a miscarriage? (Please circle)			
At this time do you have any Vaginal Discharge / Irritation / Itching / Bleeding? (Please circle)			
Do you have sex with Women / Men / Both? (Please circle)			
Do you have Vaginal / Oral / Anal sex? (Please circle)			
Do you have a partner who has multiple partners? No () Yes () Unknown ()			
Do you have a partner who is at risk for STD/HIV? No () Yes () Unknown ()			
Do you have a partner who is bisexual? No () Yes () Unknown ()			
First day of last period:			
When was the last time you had sex? _____	How many partners did you have in the past 12 months? _____		
Do you want to start or change your birth control method? No () Yes ()	Do you have any problems with your period? No () Yes ()		
What are you using for Birth Control now? _____			
What do you want to use? _____			

All information given to Health Quarters is kept confidential

-----Staff Use Only-----

- History reviewed
- BCMs discussed
- STDs discussed
- HIV/ABC discussed
- ECPs discussed
- Adolescents:
 - Family Involvement encouraged
 - Abstinence encouraged