

INTERIM HISTORY

Today's Date _____

Why are you here today? _____
Name _____ Birthdate _____ Age _____
Address _____ Apartment # _____
City _____ State _____ Zip Code _____ County _____
Home Phone _____ Work Phone _____ Message Phone (who) _____
Name of School if you are a student _____

PLEASE CIRCLE ALL THE WAYS WE MAY CONTACT YOU

Call Home Call Work By Letter Leave Message With _____

CURRENT MEDICAL HISTORY

First day of last menstrual period: _____ Was is Normal? Yes No.
Have you had sex without birth control since your last period? Yes No.
When was the last time you had sex without birth control since your last period? _____
Are you using birth control now? Yes No. What Method? _____
How long have you been using this method of birth control? _____
Any problems with method? Yes No. If yes, explain _____
Do you want to change birth control methods? Yes No. If yes, to what? _____

Any new partners last 2 months? Yes No. More than one partner last 2 months? Yes No
Any serious illnesses in your family? Yes No. If yes, what? _____
Have you seen a doctor since your last visit to this clinic? Yes No.
If yes, for what reason? _____

Have you had any of these in the past year – check all that apply:
Headaches or visual changes Abnormal Pap smear
Unusual vaginal discharge Pain with Sex
Infection of uterus or tubes (PID) Severe pain in legs, chest, or abdomen

Have you had a pregnancy, miscarriage, or abortion since your last visit to this clinic? Yes No. If yes, give date and outcome _____
Are you breast-feeding now? Yes No.
Are you taking any medication now? Yes No. If yes, please list _____

Do you smoke? Yes No. If yes, # cigarettes/day _____. Have you quit? When _____
Since your last visit have you used street drugs Yes No List: _____
Since your last visit have you used alcohol Yes No How many drinks/week: _____
Is there anyone in your life who makes you feel unsafe? Yes No
Are you interested in receiving information about your weight or diet? Yes No.
If "Yes," what would you like to know? _____
Do you have any other problems, concerns, or worries you would like to discuss? Yes No
If yes, please list _____

Patient Signature _____

Staff Signature _____