All records are CONFIDENTIAL. Information is released only with your written permission or as required by law.

### Medical & Wellness History

Have you ever been diagnosed or treated for any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
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<tr>
<td>High Cholesterol</td>
<td></td>
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<tr>
<td>Depression/Anxiety</td>
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<tr>
<td>High Blood Pressure</td>
<td></td>
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<tr>
<td>Migraine Headaches</td>
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</tr>
</tbody>
</table>

- Cancer
- Blood Clots
- Kidney Disease
- Liver Disease
- Any operations?
- Other ______

Medications being taken: __________________________

List all allergies: __________________________

Do you smoke?  □ Yes □ No  How much? __________

Do you use alcohol? □ Yes □ No  How much? /How often?

Are you satisfied with your current weight?  □ Yes □ No

Do you exercise? □ Yes □ No  What type? ______

Have you tried to lose weight or control your weight by vomiting, diet pills, or not eating? □ Yes □ No

During the past month: Have you often been bothered by feeling down, depressed, or hopeless? □ Yes □ No

During the past month: Have you often been bothered by little interest or pleasure in doing things? □ Yes □ No

### Family History

Have any of your immediate family members had any of the following? (Please indicate age at diagnosis).

- Blood Clot Disorder
- Cancer
- Diabetes
- Heart Disease/Attack
- High Blood Pressure
- High Cholesterol
- Stroke

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age</th>
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</table>

Age of first intercourse

Are you currently sexually active? □ Yes □ No

Are you □ Married □ Partnered □ Single □ Divorced?

How long have you been with your current partner? ______

Are your partners: □ men □ women □ both

Have you felt verbally or physically threatened in your current or past relationships? □ Yes □ No

Any burning with urination, penile/vaginal discharge? ______

Have you ever had a sexually transmitted disease? ______

Any history of sexual dysfunction? ______

### For patients with a uterus and cervix:

Is this your first pelvic exam? □ Yes □ No

Any abnormal Pap Smears? □ Yes □ No

If yes, date(s) ______ procedures ______

Date of last Pap ______ result ______

Have you had the HPV vaccine? □ Yes □ No

Age of first period: _____ 1st day of last period: ______

How often do you have a period? □ 28 days □ 30 days □ other ______

How many days of bleeding each cycle: ______

Days of heavy bleeding: ______

Do you experience severe menstrual cramps? □ Yes □ No

### Contraception/Disease Prevention

What is your current method of birth control and/or method for prevention of STDs?

- □ Yes □ No

If yes, type: ______

Do you want a prescription for a birth control method?

- □ Yes □ No

If yes, type: ______

### Pregnancy History

Have you ever been pregnant? □ Yes □ No □ Unsure □ N/A

If yes, what was the outcome?

□ # of births ______ □ # of miscarriage ______

□ ectopic pregnancy □ # of abortion ______

Complications of pregnancy? ______

Could you currently be pregnant? □ Yes □ No □ Unsure □ N/A

### Any particular concerns or questions we need to discuss today?

I have personally reviewed and discussed this form with the patient.

Provider Signature __________________________ Date ____________

1.4.2017