Last Name: _____First Name: _____ Middle Initial: _____

Maiden Name: _____Age: _____ Date of Birth: _____ SS# _____

Address: _____
Street City State Zip

Home Phone: _____Cell Phone: _____ Work Phone: _____

Email Address: _____

Race (Check **all** that applies):

☐ White ☐ Black ☐ Native American/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non Hispanic

Primary Language: ☐ English ☐ Spanish ☐ Other (identify) _____

Please check *EVERY* way we may contact you:

☐ Call your home ☐ Call your home, do not identify ourselves ☐ Email

☐ Call your cell ☐ Call your cell, do not identify ourselves ☐ Send mail, use plain envelope

☐ Call your work ☐ Call your work, do not identify ourselves ☐ Text cell

☐ Other (identify) _____

Emergency Contact: _____
Name Relationship Phone

How did you hear about us? (Check one)

☐ Other FP Clinic ☐ Social/Church Agency ☐ Family/Friend ☐ WIC or HMHK

☐ Hospital/Health Agency ☐ School ☐ Media/Phone Book/Internet ☐ IBCCP

☐ Private Doctor ☐ Other Patient ☐ Hotline ☐ DHS Office

What is the reason for your visit? _____

Are you having any problems? _____

I would also like information on: ☐ Smoking Cessation, ☐ Substance Abuse, ☐ Nutrition

Your private doctor/clinic: _____Hospitalizations/Surgeries/Major injuries: _____

List currently using and past medications: _____

Indicate any medical care in the past year: _____

Have you been immunized for? ☐ Rubella ☐ tetanus ☐ hepatitis B ☐ HPV

Any Family History Of? Include only parents, brothers and sisters. (If adopted may disregard if unknown)

☐ Heart Disease/High Cholesterol/High Blood Pressure _____

☐ Diabetes _____

☐ Breast Cancer _____

☐ Other _____

Confidentiality will be maintained on all records and conversations. Information or records will only be released to others with your written consent, except when necessary to provide other services, or as required by law, with appropriate safeguards for confidentiality.

Do <u>YOU</u> have now or have you ever had:

□ Cancer (1)
□ Heart Problems/Murmurs (2)
□ Stroke (3)
□ High Cholesterol (4)
□ High Blood Pressure (5)
□ Blood Clots (6)
□ Anemia (7)
□ Diabetes (8)
□ Migraine Headaches (9)
□ Seizures (10)
□ Blood Transfusion Prior to 1984 (11)
□ Depression/Emotional Problems (12)
□ Allergies/Drug Reactions (13)
□ Genetic Problems (14)
□ Asthma/TB/Difficulty Breathing (15)
□ Mono/Hepatitis/Liver problems (16)
□ Stomach/Intestinal Problems (17)
□ Gallbladder Problems (18)
□ Kidney/Bladder Problems (19)
□ Thyroid Problems (20)
□ Other Medical Conditions (21)

Staff Comments: _____
_____

□ Unusual Vaginal Discharge/Odor (1)
□ Frequent Vaginal Infections (2)
□ Vaginal Itching/Burning/Sores (3)
□ PID/uterine/tube/ovary infection (4)
□ Pain/Bleeding with Intercourse (5)
□ Unusual/Missed Periods (6)
□ Spotting/Bleeding Between Menses (7)
□ Uterine Growths/Fibroids (8)
□ Abnormal Pap Smear (9)
□ Chlamydia/Gonorrhea (10)
□ Genital Warts (11)
□ Herpes (12)
□ Syphilis (13)
□ HIV/AIDS (14)
□ Other STD (15)

Staff Comments: _____
_____

Is this your first pelvic exam? _____ If no, date and result of last Pap smear? _____
First day of your last normal period? _____ (Month/Day/Year)
How often do you get your periods? Every _____ days. How many days do you bleed? _____
Are your periods: □ light □ medium □ heavy flow Age your periods began? _____
If born prior to 1972 did your mother take any medication to prevent miscarriage? Yes _____ No _____ Unknown _____
Are you currently sexually active? Yes_____ No_____ Age at First Intercourse: _____
Have you had sex without using birth control since your last period? Yes _____ No _____

Total number of pregnancies: _____ List month & year each pregnancy ended: _____
Number of Births: _____ Living Children: _____ Miscarriages: _____ Abortions: _____ Stillbirths: _____
Complications with any pregnancies? (e.g. toxemia, diabetes, genetic problems) Yes _____ No _____
If yes, explain _____
Have you ever had an ectopic (tubal) pregnancy? Yes _____ No _____ Premature delivery? Yes _____ No _____
Are you currently breastfeeding? Yes _____No _____

What have you used for birth control? Check all that apply. What method do you want to use? _____

□ Pills
□ Patch
□ Ring
□ Sterilization/Male
□ Sterilization/Female
□ IUD/IUS
□ Depo Shot
□ Hormone Implant
□ Diaphragm
□ Sponge
□ Male Condom
□ Female Condom
□ No method
□ Spermicide
□ Other Method
□ Abstinence
□ FAM/NFP
□ Withdrawal

Any problems with any method(s)? _____

Do you smoke? No □ Yes □ If yes, how much: _____
Do you drink alcoholic beverages? No □ Yes □ If yes, What/How much/How often: _____
Do you now or have you ever used illegal drugs? No □ Yes□ If yes, what and how often? _____

Do you have sex with: Males _____ Females _____Both _____ How many sexual partners have you had in the last year? _____
Have you been diagnosed with a sexually transmitted infection in the past three years? Yes _____ No _____
Have you changed sex partners in the past three months? Yes _____ No _____
Have you and/or your partner(s) had: Oral sex _____ Anal sex _____ Vaginal sex _____
Are you in a relationship with a person who physically hurts or threatens you? Yes _____No _____
Has anyone forced you to have sex when you did not want to or make you do things sexually that you did not want to do? Yes _____ No _____
Do you feel that any of your partners have put you at risk for an STD or HIV? Yes _____ No _____
Have you ever had a sex partner with a history of injected drug use? Yes _____ No _____
Do you have sex with men who have sex with men? Yes _____ No _____
What are you doing to protect yourself from HIV/AIDS? _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of Client _____ Date _____

Signature of Staff Completing Intake_____

6/87 Revised 9/08, 3/11, 11/12, 2/13, 9/14