RILEY COUNTY HEALTH DEPARTMENT

HEALTH HISTORY FORM A

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

Name ____ Date of Birth ______________ Age ______

Pronoun: _________ Gender: ___________ Sex: __________

Are you allergic to any medications, food, other? ______ No ______ Yes List: __________________

Start date of last period _________________ Age you first started having periods _________________

GENERAL HEALTH

Have you ever had/do you have?

No	Yes		No	Yes	
☐	☐	Diabetes/Thyroid Problem	☐	☐	Problems with kidneys or bladder
☐	☐	Seizures	☐	☐	Cancer
☐	☐	Heart attacks or strokes	☐	☐	High blood pressure/ cholesterol
☐	☐	Hepatitis (skin turned yellow) or gallbladder problems	☐	☐	Problems with muscles/bones
☐	☐	Depression	☐	☐	Migraines or bad headaches
☐	☐	Blood clot in blood vessels (leg or lung)	☐	☐	Blood transfusions
☐	☐	Problems with vision or hearing	☐	☐	Respiratory problems (asthma)
☐	☐	Migraines with aura	☐	☐	Breast surgery or problems
☐	☐	Uterine fibroids or ovarian cysts	☐	☐	Pelvic infections
☐	☐	Shortness of breath	☐	☐	Anemia

☐ ☐ Have you ever had any other medical conditions, surgery or been hospitalized? If yes, explain
____

Do you chew/smoke/vape tobacco? _____ No _____ Yes If yes, how many cigarettes/cans/liquids a day? _____

How many months or years? _____How many alcoholic beverages do you drink per day_____, week _____, month ____?

Are you worried about your alcohol use? ____No ____Yes

Do you currently use street drugs? ____No _____ Yes If yes, which ones and how many time a week? _________________

Do you or have you ever used injectable drugs? ____ No ___ Yes If yes, how often? _____________ Last time used? _____

List the medications you are taking, how often and how much.

***Include prescriptions, over the counter (Ibuprofen, Tylenol), herbs, & vitamins

____

____

If age 50 or older, had you had a colon cancer screening? _____ No ____ Yes

IMMUNIZATIONS

Please give the dates of your last immunizations. (A tetanus booster is recommended every 10 years.)

_____ MMR (1 or 2 doses) ____ Td/TDaP ____ Hepatitis B Series _____HPV ______Flu

FAMILY HISTORY

Are you adopted? _____ No _____ Yes (If yes, and you do not know your family history, you are done with this section.)

Have any of your blood relatives had the following conditions? Please say who they are (mother, father, brother, sister)

____ Diabetes _______________ ____ High cholesterol/triglycerides __________ ____ Sickle Cell Anemia__________

___ Cancer ______Type_______ ____ High blood pressure ________________ ____ Stroke _____________________

___ Phlebitis/clots in veins_______ at what age __________? _____ Heart disease/attack ________ at what age? _________

If born before 1971, did your mother receive DES (hormones) to prevent miscarriage? _______No ______ Yes

PSYCHOSOCIAL

Do you have any problems at home, work, or school that are bothering you? _____No _____ Yes

If yes, please explain ____

PREGNANCY/ PARENTING

Over

Have you ever been pregnant? ___ No ____ Yes

Do you intend to become pregnant in the next 18 months? NO, definitely not ☐ No, probably not ☐

Yes, Definitely ☐ Yes, probably ☐

Age at first pregnancy ____ # of pregnancies______ # of deliveries_____ Complete Date of last delivery_______

# of miscarriages___ # of abortions_____ # of ectopic _____ Currently breastfeeding? ______

For clients who have not had children yet:

How many children would you like to have in your lifetime? _____________

At what age would you like to start having children? ____________________

SEXUAL

How old were you when you first had intercourse? _______ Was it consensual? ____ If no, explain ________________

When you were young did someone ever touch you inappropriately in sexual way? _______No ______Yes

Please explain:____

Were/are your sexual partners: ☐ men ☐ women ☐ IV drug users ☐ partner with multiple partners or at risk for HIV/STD

☐ Sexual assault situation ☐ Other:_______________________

Have you tested positive and/or been ☐eated for a sexually transmitted disease in the past year? ___ No ____ Yes

If yes, when and what disease? ____

Have you had a new sexual partner or more than one sexual partner in the last year? ____ No ____ Yes How many? _____

How many partners have you had in your lifetime? _________________

Have you ever been physically abused (hit, kicked, slapped)? _______ No _______ Yes ____Current situation?

Have you ever been emotionally abused (threatened, made to feel worthless)? _____ No _____ Yes ____ Current situation?

Has anyone, including a partner or family member ever forced you to have sex? ____No _____ Yes __ Current situation?

What types of sex have you had? Oral ☐ Anal ☐ Vaginal ☐ None ☐ Other:__________________

What do you do to protect yourself from being infected with HIV/STDs? _________________________

CONTRACEPTIVES

If you are sexually active with male(s) and not desiring pregnancy, are you currently using birth control to prevent pregnancy? **If so, what method**? ____

Please mark all methods of contraception that you have used in the past:

☐ Male condoms ☐ Female Condoms ☐ Combine Hormone Contraceptive Pills ☐ Diaphragm

☐ Hormonal Implant (Nexplanon, Implanon) ☐ Hormonal IUD ☐ Non-Hormonal IUD ☐ Vaginal Ring

☐ Contraceptive Patch ☐ Progesterone Only Pill ☐ Emergency contraception ☐ Shot