OTTAWA COUNTY HEALTH DEPARTMENT

Ottawa County Reproductive Health Clinic
Patient History Questionnaire

First name: _____ Last name: _____

Today's date: _____ Date of birth: _____

List any concerns you want to talk about during your visit: _____

_____

Health history:	
Do you have diabetes? ☐ Yes ☐ No High blood pressure? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No	Do you have other health conditions? _____ _____
Please list all surgeries (date and reason) or any recent hospitalizations	_____ _____ _____
Please list all allergies and reactions	_____ _____ _____

Social, Emotional and Physical Wellness:	
Do you smoke cigarettes?	☐ Never ☐ Yes _____# packs/day ☐ Quit Date quit_____ Years smoked _____
Do you vape (e-cigarettes)?	☐ No ☐ Yes
Do you drink alcohol?	☐ Never ☐ Yes _____# drinks per week
Do you use recreational drugs?	☐ Never ☐ Rarely _____# times per month ☐ Marijuana ☐ Cocaine ☐ Opioids ☐ Other_____
Interested in quitting?	☐ Yes ☐ No
What is your highest level of education completed?	☐ High School ☐ Trade school ☐ College ☐ Post-graduate degree(s)
Are you employed?	☐ No ☐ Retired ☐ Yes Type of work_____
Do you exercise?	☐ No ☐ Yes Type _____ How often_____How long per activity_____
Do you feel you are getting enough to eat each day from all food groups?	☐ Yes ☐ No ☐ Unsure

Do you have enough money for groceries and living expenses?	☐ Yes ☐ No ☐ Unsure
Do you have a place to live?	☐ Yes ☐ No
Do you have transportation?	☐ Yes ☐ No
What is your marital status?	☐ Married ☐ Partnership ☐ Divorced ☐ Separated ☐ Single ☐ Widow/er
Are you sexually active?	☐ No ☐ Yes # of sexual partners _____ ☐ Men ☐ Women ☐ Both Contraception: ☐ No ☐ Yes If yes, method _____
How would you best describe your gender?	☐ Male ☐ Female ☐ Transgender ☐ Nonbinary ☐ Other:_____
How would you best describe your sexuality?	☐ Straight ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Other:_____
Are you at risk for an STI?	☐ Yes ☐ No ☐ Unsure
Do you have children?	☐ No ☐ Yes # of children_____ages _____
Would you like to have more children in the next 12 months?	☐ Yes ☐ No ☐ Unsure
If yes, do you take folic acid supplements daily?	☐ Yes ☐ No ☐ Unsure
If yes, have you or your partner recently traveled to an area of high transmission of Zika Virus?	☐ Yes ☐ No ☐ Unsure
Do you feel safe in your current relationship and/ or home?	☐ Yes ☐ No ☐ Unsure
How often do you get the social and emotional support you need?	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
Have you ever been emotionally, physically, or verbally assaulted by someone?	☐ Yes ☐ No ☐ Unsure
Have you ever been forced to do something sexually that you didn't want to do?	☐ Yes ☐ No ☐ Unsure
Have you ever had sexual intercourse under the influence of alcohol and/or other drugs?	☐ Yes ☐ No ☐ Unsure

Life Plans:	
If you do not have children, do you know when you would like to have your first child?	☐ Yes ☐ No ☐ Unsure
If you become pregnant, what will you do?	
Do you know about safe spacing between children?	☐ Yes ☐ No ☐ Unsure
If you do not have a partner, please skip the following questions	
Do you and your partner *trust* each other?	☐ Yes ☐ No ☐ Unsure
Do you and your partner *respect* each other?	☐ Yes ☐ No ☐ Unsure
Do you and your partner *support* each other?	☐ Yes ☐ No ☐ Unsure
Do you and your partner *communicate* with each other?	☐ Yes ☐ No ☐ Unsure
Are you able to go out with friends without your partner?	☐ Yes ☐ No ☐ Unsure
Do you have a good relationship with your parents/ support person?	☐ Yes ☐ No ☐ Unsure

What are your life goals?

_____

_____

_____

If you are under the age of 18, please answer the following:	
Have you told one or both of your parents or any adult about your decision to seek family planning services?	☐ Yes ☐ No
*If yes? Who?*_____	
Do you live with your parents?	☐ Yes ☐ No

Family history:		
Relation	**Health conditions**	**Family history of cancer?**
Mother		If yes, list relative and type of cancer.
Father		
Children		
Brother/Sister		

Preventive care:			
Have you received any of the following vaccines?	☐ Flu	Date:	Place:
	☐ HPV	Date:	Place:
	☐ Tetanus	Date:	Place:
	☐ Hepatitis B	Date:	Place:
	☐ Other	Date:	Place:
Recent tests or procedures	☐ Colonoscopy	Date:	Place:
	☐ Colposcopy	Date:	Place:
	☐ Mammogram	Date:	Place:
	☐ PAP	Date:	Place:
Other:			

Specialists:		
Provider's first and last name	**Specialty**	**Town / City**

Medications:	
Name	**Dose/ Times per day**

Pharmacies:		
	Name	**Location**
Local		
Mail order		

Symptoms: Please check any symptoms you have now or have had in the past 3 month.

General	Heart/circulation	Musculoskeletal	Nervous System
☐ Fever	☐ Chest pain	☐ Joint pain	☐ Numbness
☐ Chills	☐ Heart pounding	☐ Neck pain	☐ Weakness
☐ Feeling poorly	☐ Fast pulse	☐ Joint swelling	☐ Dizziness
☐ Feeling tired	☐ Slow pulse	☐ Joint stiffness	☐ Fainting
☐ Weight gain	☐ Leg pain with exercise	☐ Muscle aches	☐ Confusion
☐ Weight loss	☐ Leg swelling	☐ Back pain	☐ Headache
Eyes	**Ear/nose/throat**	**Skin**	**Reproductive**
☐ Eye pain	☐ Earache	☐ Sores	☐ Erection problems
☐ Red eyes	☐ Loss of hearing	☐ Rash	☐ Lump in testicle
☐ Eyesight problems	☐ Nosebleeds	☐ Itching	☐ Discharge from penis
☐ Discharge from eyes	☐ Runny nose	☐ Change in a mole	☐ Breast lump
☐ Dry eyes	☐ Sore throat	☐ Unusual growth/spot	☐ Nipple discharge
☐ Itchy eyes	☐ Hoarseness		☐ Abnormal Pap smear
Breathing	**Gastrointestinal**	**Psychiatric**	☐ Irregular bleeding
☐ Coughing	☐ Stomach pain	☐ Thoughts of harm to self or others	☐ Bad cramps
☐ Wheezing	☐ Upset stomach/ vomiting	☐ Sleep problems	☐ Pelvic pain
☐ Shortness of breath	☐ Diarrhea	☐ Anxiety	☐ Pain during sex
☐ Trouble breathing during exercise	☐ Constipation	☐ Depression	☐ Vaginal discharge
☐ Trouble breathing while lying down	☐ Heartburn	☐ Change in personality	Last period _____
☐ Snoring	☐ Blood in stool	☐ Emotional problems	Last Pap smear _____
Blood	**Endocrine**	**Genital and urinary**	Mammogram_____
☐ Bleed easily	☐ Hot flashes	☐ Pain when urinating	Are you pregnant?___
☐ Bruise easily	☐ Muscle weakness	☐ Abnormal urination	# of pregnancies_____
☐ Swollen glands in neck	☐ Voice changes	☐ Urinate often at night	# of babies delivered ___
	☐ General weakness	☐ Genital sores	# of miscarriages/ abortions _____

List other symptoms:

_____

_____

_____

Patient signature:_____ Date: _____

Nurse signature:_____ Date: _____

Provider signature:_____ Date: _____