NAME_____DATE OF BIRTH_____

Florida Department of Health, Hernando County Medical History Form

Allergies of Any Kind (drugs, pets, food)- _____
Describe reaction _____

Patient Past Medical History

Do you, or have you ever had, any of the following?	Yes	No	If Yes, List Specific Problem and Date First Diagnosed if Known
ADD/ADHD			
AIDS/HIV			
Asthma/Lung Disease			
Alzheimer or Dementia			
Anemia/Blood Disorder/Sickle Cell Disease or Trait			
Birth Defect/Genetic Problem			
Received Blood or Blood Products			
Bone or Joint Problems			
Bruise Easily or Excessive Bleeding			
Cancer			
Chronic Pain			
Diabetes			
Eye, Ear, Nose or Throat Problem			
Fainting Spells or Frequent Dizziness			
GI/Reflux/Stomach or Bowl Problems			
Headache-Severe or Migraine			
Heart Disease or Attack			
High Blood Pressure			
High Cholesterol			
Kidney Disease or Bladder Problems			
Liver or Gallbladder Problems			
Mental Illness, Emotional Problems			
Seizure Disorder or Epilepsy			
Skin Problems			
Stroke			
Thyroid/Endocrine Disorder			

Family Medical History

Father: ____ Living ____ Deceased ____ Unknown **Mother:** ____ Living ____ Deceased ____ Unknown
If deceased list age and cause of death: (ex. Lung cancer, heart attack, stroke)

_____

List any known diseases that you know your father or mother had:

_____

_____

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Past Surgeries and Hospitalizations

List any surgeries you have had and year: _____

_____

List any significant Injuries you have had that required treatment and date:

_____

List any hospitalizations where you were in the hospital for longer than 24 hours and list why and date:

_____

_____

Immunizations

Up to date _____ yes _____ no _____ unknown

Reproductive Life Plan

Have you thought about having children or more children? ☐Yes ☐No ☐Undecided

If yes/undecided

Have you thought about how many children you would like to have?

☐1 ☐2 ☐3 or more ☐Not Sure

Are you interested in getting pregnant or starting a family?

☐Within the next year ☐1 - 3 years ☐More than 3 years

If No

How important is it to you to prevent pregnancy?

☐Not sure / I don't want to be pregnant now / I don't want to get someone pregnant

☐Important (want to wait 1 - 2 years)

☐Very important (want to wait 3 or more years)

☐Very important (wants permanent protection)

Are you currently using a birth control method? ____ Yes ____ No

If yes, list method: _____

Are you happy with your method? _____Yes _____ No

Do you feel that you:

Use your birth control consistently?	☐ Always	☐ Sometimes	☐ Never
Use your birth control correctly?	☐ Always	☐ Sometimes	☐ Never

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Female Patients

Menopause? ____ Yes ____ No If yes, age at Menopause _____ Hormone Replacement? ____ Yes ____ No

(If menopause, do not answer the rest of the questions)

Date of 1st day of last period: _____Periods come every _____ days and last _____ days.

Menstrual Periods are ____ Regular ____ Irregular If irregular, describe_____

Menstrual pain: ___None ___ Mild ____ Moderate ____ Severe

Do you have bleeding between periods? __ Yes___ No

Do you perform self-breast exams? ____ Yes ____ No Have you ever had a mammogram? ____ Yes ____ No

Date of Last Mammogram _____ Have you ever had an abnormal mammogram? ____ Yes ____ No

If yes, list date and describe: _____

Date of last Pelvic Exam: _____ Last PAP Exam: _____Have you ever had an abnormal PAP? ____Yes ____ No

Have you ever had an abnormal HPV Test? ____ Yes____ No

If yes to either PAP or HPV list date and treatment if known: _____

— Pregnancy History

Number of times pregnant (Gravida) G		Age at first pregnancy	
Number of full-term births (Term) T		Number of stillbirths	
Number of pre-term births (Preterm) P		Number of C-sections	
Number of spontaneous abortions (Abortus) AS		Number of Ectopic pregnancies	
Number of induced abortions (Abortus) AI			
Number of living children (Living) L			
How long ago was your last pregnancy	Years		
	Months		

Other Pregnancy Comments

Social History

— Safety

Do you use seatbelts when driving or riding in a vehicle?

☐ Yes ☐ Sometimes ☐ No ☐ Rarely ☐ N/A

Are children and other passengers properly restrained when riding with you?

☐ Yes ☐ Sometimes ☐ No ☐ Rarely ☐ N/A

Do you wear a helmet when riding a motorcycle or bicycle?

☐ Yes ☐ Sometimes ☐ No ☐ Rarely ☐ N/A

Appropriate safety counseling given:

☐ Yes ☐ No

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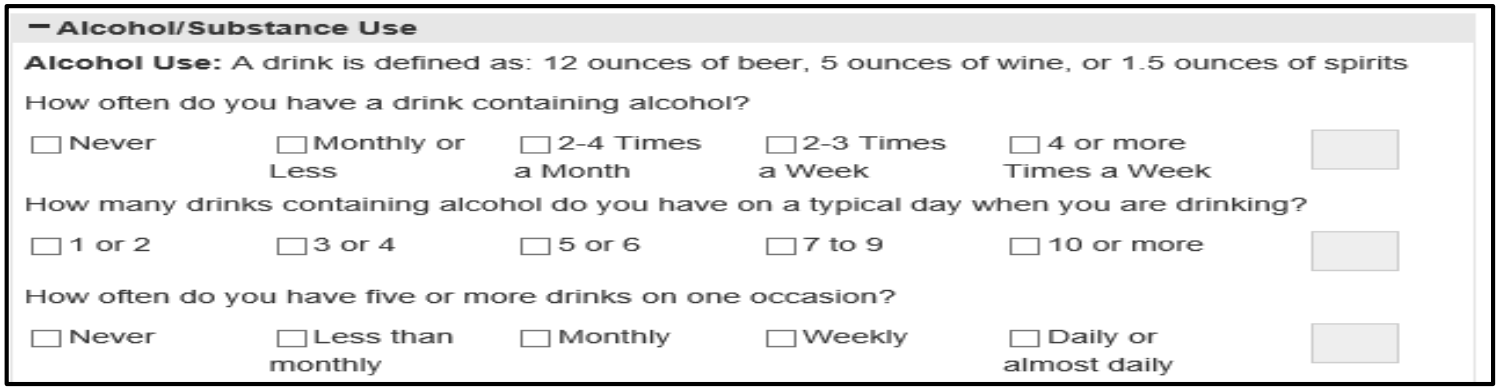

Alcohol/Substance Use

Alcohol Use: A drink is defined as: 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of spirits

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or Less ☐ 2-4 Times a Month ☐ 2-3 Times a Week ☐ 4 or more Times a Week

How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have five or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

How many times **in the past year have you** used an illegal drug or used a prescription medication for non-medical reasons? _____

Do you or have you ever smoked cigarettes or used tobacco or nicotine products? ____ Yes ____ No
If yes, indicate products: Cigarettes _____Packs per day ____ E-cigs ____ Pipe ____ Hookah ____ Dip ____
Clove Cigs ____ Other: _____ _____At what age did you start using tobacco products? _____
What is your current smoking status?
____ Never Smoker (no more than 100 cigs in a lifetime)
____ Former Smoker (more than 100 cigs in a lifetime but not current smoker)
____ Current Some Day Smoker (at least 100 cigs in lifetime + still smoking periodically)
____ Current Every Day Smoker (at least 100 cigs in lifetime + smoking currently every day)
____ Heavy Smoker (greater than 10 cigs per day)
____ Light Smoker (less than 10 cigs per day)
Would you like a **referra**l to help you with your tobacco use habit? ____ Yes ____ No

Do you regularly eat 5 or more fruits & vegetables per day? ___Yes ___No
Do you regularly spend 2 or more hrs./day in recreation screen use (TV, video games, computer)? ____ Yes ____No
Do you regularly get at least one hour of moderate physical activity a day? ____ Yes ____ No
Do you regularly limit consumption of sugary drink? ____ Yes ____ No

Sexual History

Are you currently sexually active? ____ Yes ____ No
Have you ever injected drugs? ___ Yes____ No
Have you ever exchanged money or drugs for sex? ____ Yes ____ No
In the last **2 months**, how many sexual partners (including casual/ one night stands) have you had? Total _____
Male _____ Female _____
In the last **12 months**, how many sexual partners (including casual/ one night stands) have you had? Total _____
Male _____ Female _____
Have you ever had sex with someone who injected drugs? ____ Yes ____ No ____ Unknown
Have you ever had sex with someone who exchanged money or drugs for sex? ____ Yes ____ No ____ Unknown

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What are you or your partner(s) doing to protect yourself against STD's and HIV?
_____Male condoms _____Female condoms _____ Dental dam _____ Other _____None
Have you ever been diagnosed with a Sexually Transmitted Disease? ____ Yes ____ No
If yes: Check which disease, number of times diagnosed and date of last diagnosis.

STD Diagnosis	# of times Diagnosed	Date of Last Diagnosis
Gonorrhea		
Chlamydia		
Syphilis		
Herpes		
HPV		
Pelvic Inflammatory Disease (PID)		
Bacterial Vaginosis (BV)		
Trichomoniasis		

Have you ever been tested for HIV? ____ Yes ___ No. Date of last test_____
If HIV positive, please complete following section:

HIV General

HIV/AIDS Status

☐ HIV positive; not AIDS ☐ HIV positive; AIDS status unknown ☐ CDC defined AIDS

HIV/AIDS diagnosis

Date of initial HIV positive test ☐ Imprecise
Date of AIDS Diagnosis ☐ Imprecise
Proof of positive/RW eligibility HIV test ☐ Imprecise
HIV/AIDS diagnosis comments

Prior medical care

Prior medical care for HIV? ☐ Yes ☐ No
Prior medical care comments

Exam Dates

Date of last annual physical exam ☐ Imprecise
Date of last annual physical exam comments
Date of last dental exam ☐ Imprecise
Date of last dental exam comments

History of AIDS-Defining Conditions

☐ CD4 Cell Count less than 200 cells/mm(superscript 3) for millimeter cubed
☐ CD4 % less than 14%
☐ Bacterial infections, multiple or recurrent
☐ Candidiasis of bronchi, trachea, esophagus, or lungs
☐ Cervical cancer, invasive
☐ Coccidioidomycosis, disseminated or extrapulmonary

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Domestic violence, sexual assault, and human trafficking

1. Have you been physically hurt (hit, pushed, shoved, burned, slapped, and/or bitten) , insulted, or threatened (to take away income, children, and/or pets) by your loved one, partner or significant other?
   ☐ Yes ☐ No ☐ Refuses to answer ☐ Other
2. Have you been touched sexually against your will or without your consent?
   ☐ Yes ☐ No ☐ Refuses to answer ☐ Other
3. Is anyone forcing you to do work that you do not want to do (i.e. have you been threatened and/or can you come and go as you please)?
   ☐ Yes ☐ No ☐ Refuses to answer ☐ Other

Domestic violence, sexual assault, and human trafficking screening comments

Sexual Orientation

− Sexual Orientation

Do you think of yourself as:

☐ Lesbian, Gay or Homosexual ☐ Straight or Heterosexual ☐ Bisexual

☐ Something else, please describe ☐ Don't know ☐ Choose not to disclose

− Gender Identity

Do you think of yourself as:

☐ Male

☐ Female

☐ Male to Female (MTF)/Transgender Female/Trans Woman

☐ Female to Male (FTM)/ Transgender Male/ Trans Man

☐ Genderqueer (neither exclusively male or female)

☐ Additional Category/Other

☐ Choose not to disclose

What sex were you assigned at birth?