### Florida Department of Health, Hernando County Medical History Form

**Allergies of Any Kind** (drugs, pets, food)
- ________________________________
  Describe reaction ____________________________________________________________

**Patient Past Medical History**

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

**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: _____________________________________________

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
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 referral 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.

<table>
<thead>
<tr>
<th>STD Diagnosis</th>
<th># of times Diagnosed</th>
<th>Date of Last Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea</td>
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<tr>
<td>Chlamydia</td>
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<td>Syphilis</td>
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<td>Herpes</td>
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<tr>
<td>HPV</td>
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<tr>
<td>Pelvic Inflammatory Disease (PID)</td>
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<tr>
<td>Bacterial Vaginosis (BV)</td>
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<tr>
<td>Trichomoniasis</td>
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</tbody>
</table>

Have you ever been tested for HIV?  ____ Yes  ____ No. Date of last test ____________________________

If HIV positive, please complete following section:

<table>
<thead>
<tr>
<th>HIV General</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS Status</td>
</tr>
<tr>
<td>HIV positive; not AIDS</td>
</tr>
<tr>
<td>HIV positive; AIDS status unknown</td>
</tr>
<tr>
<td>CDC defined AIDS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIV/AIDS diagnosis</th>
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</thead>
<tbody>
<tr>
<td>Date of initial HIV positive test</td>
</tr>
<tr>
<td>Date of AIDS Diagnosis</td>
</tr>
<tr>
<td>Proof of positive/RW eligibility HIV test</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIV/AIDS diagnosis comments</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Exam Dates</th>
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</thead>
<tbody>
<tr>
<td>Date of last dental exam</td>
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<tr>
<td>Date of last dental exam comments</td>
</tr>
</tbody>
</table>

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

- 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?

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