NAME_____DATE OF BIRTH_____

PLEASE PRINT

Florida Department of Health, Hernando County Medical History Form

Allergies of Any Kind (drugs, pets, foods, chemicals)_____

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:

_____

_____

Past Surgeries and Hospitalizations

List any surgeries you have had and the year(s): _____

_____

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

List any hospitalizations where you were in the hospital for longer than 24 hours; give the reason(s) and date(s):

List all medications you are taking: (use the back of the form if needed)

_____
_____
_____
_____

Dates of Immunizations:

Up to date _____ Yes _____ No _____ Unknown

Reproductive Life Plan

Have you ever 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 (want 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
Do you feel you use your birth control correctly? _____ Always_____ Sometimes_____ Never

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Female Patients

Menstrual History:

Age of onset for 1st period: _____

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

Menopause? ____ Yes____ No If yes, age at Menopause _____ Hormone Replacement? ____ 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_____ Age at first pregnancy _____

Number of full terms births_____ Number of stillbirths_____

Number of pre-term births_____ Number of c-sections_____

Number of spontaneous abortions (miscarriages) _____Number of ectopic pregnancies _____

Number of induced abortions _____

Number of living children_____

How long ago was your last pregnancy _____ years _____months

Other pregnancy comments:

_____

_____

NAME_____DATE OF BIRTH_____

All Patients answer the rest of the History Questions

Safety

Do you use seatbelts when driving or riding in a vehicle? _____ Yes _____ Sometimes _____ No _____ Rarely _____ NA

Are children and other passengers properly restrained when riding with you? _____ Yes _____ Sometimes _____ No _____ Rarely _____ NA

Do you wear a helmet when riding a motorcycle or bicycle? _____ Yes _____ Sometimes _____ No _____ Rarely _____ NA

Are you exposed to any hazardous substances at home or work?

_____ No_____ Yes; name_____

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 referral to help you with your tobacco use habit? ____ Yes____ No

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All Patients answer the rest of the History Questions

Sexual History

Are you currently sexually active? _____ Yes_____ No
Have you ever been sexually active? _____ Yes_____ No
_____ Female _____ Male _____ Both

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 _____
Circle the types of sex you have had: Vaginal Oral Rectal

Have you ever injected drugs? _____ Yes_____ No
Have you ever had sex with someone who injected drugs? _____ Yes _____ No_____ Unknown

Have you ever exchanged money or drugs for sex? _____ Yes_____ No
Have you ever had sex with someone who exchanged money or drugs for sex?
_____ Yes_____ No_____ Unknown

What are you or your partner(s) doing to protect yourself against STD's and HIV? _____ Male condoms _____
Female condoms _____ Dental dam _____ Other _____ None
Do you use them all the time? _____ Yes _____ No
Do you use them correctly all the time? _____ Yes _____ No

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	Number of times Diagnosed	Date of Most Recent 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 _____

Result of last test _____

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If HIV positive, please complete following section:

_____ HIV positive, not AIDS _____ HIV positive; AIDS status unknown _____CDC defined AIDS

HIV/AIDS diagnosis Date of initial HIV positive test _____ _____ Not sure
Date of AIDS diagnosis: _____ _____ Not sure
Proof of positive/RW eligibility HIV test: _____ _____ Not sure
HIV/AIDS diagnosis comments:
_____

Prior Medical Care for HIV? _____ Yes _____ No
Comments
_____

Exam Dates
Date of last physical exam _____ _____Not sure
Comments
_____
Date of last dental exam_____ _____Not sure
Comments
_____

History of AIDS-defining conditions
_____ CD4 cell count less than 200 cells/mm3 for millimeter cubed
_____ CD4% less than 14%
_____ Bacterial infections, multiple or recurrent
_____ Candidiasis of bronchi, trachea, esophagus, or lung
_____ Cervical cancer, invasive
_____ Coccidiomycosis, disseminated or extrapulmonary

All Patients answer the rest of the History Questions

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 drinks?
_____ Yes _____ No

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All Patients answer the rest of the History Questions

Domestic violence, sexual assault, and human trafficking:
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 _____ Refuse to answer _____Other _____
Have you been touched sexually against your will or without your consent?
_____ Yes _____ No _____ Refuse to answer _____Other _____
Is anyone forcing you to do work that you do not want to do (have you been threatened or denied to come and go as you please)?
_____ Yes _____ No _____ Refuse to answer _____Other _____

Comments_____

Answering these questions will help us to take better care of you.
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 _____ Pansexual (gender blind of omnisexual)

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 nor female)
_____ Additional category/Other
_____ Choose not to disclose

What sex were you assigned at birth? _____ Male _____ Female

Additional comments or information we should know to better partner with you to improve your health.

_____

_____

_____