

## INITIAL HISTORY

D. PREGNANCY HISTORY	
# of Pregnancies:	# of Miscarriages:
# of Live Births:	# of Still Births:
# of Living Children:	# of Abortions:
# of Tubal Pregnancies:	<input type="checkbox"/> Never Pregnant
Date of Last Pregnancy:	
Do you plan to have children in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No	

E. CONTRACEPTIVE HISTORY	
Current birth control method:	
How long used?	
Any problems with this method? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what?	
What method do you want to use now?	
Circle below if any apply, Have you had a:	
<b>Tubes tied.....Hysterectomy.....Gone through menopause</b>	

F. MENSTRUAL HISTORY	
1. Age periods began	
2. Number of pads/tampons used on heaviest day: _____	
3. Length of period: _____ (days)	
4. Are your periods usually regular? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Last period started on _____	
It seemed: <input type="checkbox"/> normal <input type="checkbox"/> not normal	
6. Do your periods interfere with your life: <b>If yes please explain</b>	
7. Do you have vaginal bleeding after sex? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Do you have vaginal bleeding between menstrual periods:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

COMMENTS	

G. SOCIAL HISTORY			
YES	NO	HAVE YOU RECENTLY EXPERIENCED:	COMMENTS
		Are you currently safe?	
		Problems with parents if living at home	
		Are you physically abused?	
		Have you been sexually abused or forced to have sex?	

COMMENTS	

H. STI / HIV RISKS	
Number of sex partners in lifetime: MALE: _____ FEMALE: _____	
How many sex partners have you had during the past year?	
What percent of the time do you use condoms?	
How do you protect yourself against STD's and HIV?	

YES	NO	COMMENTS
		Have you ever used street drugs? If yes, when and what kind?
		Have you received blood or blood products before 1985?
		Did any sexual partner: <input type="checkbox"/> use needle drugs? <input type="checkbox"/> have Hemophilia? <input type="checkbox"/> have HIV / AIDS? <input type="checkbox"/> have multiple partners? <input type="checkbox"/> have partners of both sexes?
		Have you <u>shared</u> needles? Example: Injecting drugs, tattooing, piercing?
		Have you exchanged sex for drugs or money?
		Have you been tested for HIV? When?

COMMENTS	
To the best of my knowledge the information I have provided is correct and complete.	
_____	_____
Client Signature	Date
_____	_____
Staff Signature	Date
Label # 5 Here	