***CONFIDENTIAL***

North Carolina Department of Health and Human Services Division of Public Health

Place Patient Label Here

Reproductive Health Branch

**BIOLOGICAL FEMALE REPRODUCTIVE HEALTH HISTORY**

Date:

1. **GENERAL INFORMATION**
	1. May we contact you by mail? □ Yes □ No By phone? □ Yes □ No Your phone number is
	2. Do you have a primary care provider? □ Yes □ No If yes, who?

 If No a referral to a primary care provider is offered □ Yes □ No

* 1. Hearing, Visual, Language and/or Physical Accommodation needs/Primary Language(s)
	2. Highest grade completed in school

# MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

* 1. List hospitalizations, surgeries and dates:
	2. Medications: Do you take a multivitamin and/or a folic acid? □ Yes □ No Do you currently take any medications (prescription or over the counter), diet or herbal supplements? □ Yes □ No If yes, what?
	3. Self and Family Medical History: Put an **X** under **SELF** and/or **X** under **FAMILY** (parent, grandparent, brother, sister or your child)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELF** | **FAMILY** |  | **SELF** | **FAMILY** |  |
| □ | □ |  1. | Heart disease/vascular problems (heart attack, blood clots, stroke) | □ | □ |  6. |  Liver Disease |
| □ | □ |  2. Sickle Cell Disease or Trait/Blood Disorder | □ | □ |  7. |  Migraine Headache (with aura) |
| □ | □ |  3. | Diabetes/Gestational Diabetes (if postpartum and had GDM, then repeat screening) | □ | □ |  8. |  Cancer |
| □ | □ |  4. | High Blood Pressure /High cholesterol | □ | □ |  9. |  Mental Illness/Emotional Disorders |
| □ | □ |  5. | Lung Disease | □ | □ |  10.  |  Other |
|  | If yes to any of the above, please explain:  |

# GYNECOLOGICAL HISTORY

* 1. Menstrual history: At what age did you have your first period? How often do you have your period? How many days does your bleeding last? \_\_\_\_\_\_\_Do you have any concerns about your periods?
	2. Any history of gynecologic conditions such as endometriosis, fibroids, ovarian cysts, chronic pelvic pain, polycystic ovarian syndrome, infertility, etc.?
	3. Breast problems such as cysts, tumors, discharge, biopsies, or surgeries?
	4. Date of last Mammogram
	5. Date of last Pap test History of any abnormal Pap tests? □ Yes □ No If yes, in what year, what results, and what was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **Past birth control methods used:** □ OCP (type)\_\_\_\_\_\_\_\_\_\_ □ Depo □ Condoms □ BTL □ Patch
□ Ring □ Implant □ IUD □ FABM □ Other □ None

 Concerns or problems with past methods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Obstetrical History**
	1. Gravida \_\_\_\_\_\_\_\_ # Carried to term \_\_\_\_\_\_\_\_ # Preterm \_\_\_\_\_\_\_\_ #Abortion/Miscarriage <20 weeks \_\_\_\_\_\_\_\_ #Living \_\_\_\_\_\_\_\_

# SOCIAL/ENVIRONMENTAL HISTORY

* 1. Do you currently use tobacco, including cigarettes, smokeless tobacco, electronic devices, or other products?
		+ Yes □ No If yes, what type? How long?
	2. Drink alcohol? □ Yes □ No If yes, how much? How long?
	3. Use recreational drugs? □ Yes □ No If yes, what type? How often?

* 1. Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or recreational drugs?
		+ Yes □ No If yes, what do they use? How often?
1. **IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES** (UTD = up-to-date; REF = referred, and NA = not applicable)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Td/Tdap□ UTD □ REF □ NA | MMR□ UTD □ REF □ NA | Varicella□ UTD □ REF □ NA | HPV□ UTD □ REF □ NA | Hepatitis A □ UTD □ REF □ NA |
| Hepatitis B□ UTD □ REF □ NA | Meningococcal□ UTD □ REF □ NA | Pneumonia□ UTD □ REF □ NA | Inﬂuenza□ UTD □ REF □ NA |  |
|  Source of Information: □ NCIR □ Patient □ Other Written Documentation |
| Interviewer’s Signature: Date:  |
| Signature of Interpreter (if used): Date:  |