

# The Saban Free Clinic

## Confidential Adult Medical History

YOUR NAME \_\_\_\_\_ BIRTHDATE 

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LIST MEDICATIONS TO WHICH YOU ARE ALLERGIC (WRITE NONE IF NO ALLERGIES)


LIST ALL PRESCRIPTIONS OR OVER-THE-COUNTER MEDICINES OR SUPPLEMENTS THAT YOU ARE NOW TAKING:


WHEN WAS THE LAST TIME YOU SAW A DOCTOR/ CLINICIAN? FOR WHAT PROBLEM(S)?

DATES	PROBLEMS

WHEN HAVE YOU HAD SURGERY OR HAVE BEEN HOSPITALIZED? FOR WHAT PROBLEM(S)?

DATES	PROBLEMS

MAJOR INJURIES/ACCIDENTS

DATES	PROBLEMS

HAVE YOU EVER HAD A BLOOD TRANSFUSION OR RECEIVED BLOOD PRODUCTS?

YES, DATES \_\_\_\_\_  NO  DON'T KNOW

HAVE YOU BEEN IMMUNIZED AGAINST:

HEPATITIS B  YES, DATES \_\_\_\_\_  NO  DON'T KNOW  
 TETANUS  YES, DATES \_\_\_\_\_  NO  DON'T KNOW  
 RUBELLA (MMR)  YES, DATES \_\_\_\_\_  NO  DON'T KNOW  
 GARDASIL (HPV)  YES, DATES \_\_\_\_\_  NO  DON'T KNOW

### YOUR MEDICAL HISTORY

• HAVE YOU EVER HAD, OR DO YOU NOW HAVE THESE CONDITIONS (CHECK ALL THAT APPLY):

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HEART DISEASE/ATTACK    | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> GONORRHEA               |
| <input type="checkbox"/> MIGRAINE HEADACHES  | <input type="checkbox"/> STROKE                  | <input type="checkbox"/> HERPES              | <input type="checkbox"/> LIVER PROBLEM/HEPATITIS |
| <input type="checkbox"/> DEPRESSION          | <input type="checkbox"/> UTERINE TUMORS/FIBROIDS | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> CHLAMYDIA               |
| <input type="checkbox"/> PSYCHIATRIC ILLNESS | <input type="checkbox"/> DIABETES                | <input type="checkbox"/> KIDNEY PROBLEMS     | <input type="checkbox"/> BLOOD CLOT PROBLEM      |
| <input type="checkbox"/> HIGH CHOLESTEROL    | <input type="checkbox"/> CHEST PAIN              | <input type="checkbox"/> SYPHILIS            | <input type="checkbox"/> PROSTATE PROBLEM        |
| <input type="checkbox"/> SEIZURES/EPILEPSY   | <input type="checkbox"/> OVARY CYST/TUMOR        | <input type="checkbox"/> CANCER              | <input type="checkbox"/> GENITAL WARTS           |
| <input type="checkbox"/> BREAST PROBLEM      | <input type="checkbox"/> ASTHMA                  | <input type="checkbox"/> ANEMIA              | <input type="checkbox"/> OTHER _____             |

### YOUR FAMILY MEDICAL HISTORY

• HAS ANYONE IN YOUR IMMEDIATE FAMILY (MOTHER/FATHER/BROTHER/SISTER/OTHER) HAD TROUBLE WITH THE FOLLOWING?

I DO NOT KNOW MY FAMILY HISTORY

- |  |                |                                 |                                 |                                 |                                  |                                |                    |
|--|----------------|---------------------------------|---------------------------------|---------------------------------|----------------------------------|--------------------------------|--------------------|
| <input type="checkbox"/> HIGH BLOOD PRESSURE   | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> HIGH CHOLESTEROL      | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> HEART DISEASE/ATTACK  | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> STROKE                | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> ASTHMA                | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> DIABETES              | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> CANCER (TYPE: _____ ) | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> BLOOD CLOT PROBLEM    | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> BIRTH DEFECTS         | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> MENTAL ILLNESS        | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |
| <input type="checkbox"/> OTHER _____           | Family member? | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> SISTER | <input type="checkbox"/> BROTHER | <input type="checkbox"/> OTHER | At what age? _____ |

• WAS YOUR MOTHER EXPOSED TO DES (DIETHYLSTILBESTROL) WHILE PREGNANT WITH YOU?  YES  NO  DON'T KNOW

OVER, PLEASE

**TUBERCULOSIS RISK**

- HAVE YOU HAD A POSITIVE PPD?  NO  YES DATE \_\_\_\_\_
- IF YES, WHEN? \_\_\_\_\_ DID YOU RECEIVE MEDICATION?  NO  YES DATE \_\_\_\_\_
- IF YES, HAVE YOU HAD A CHEST X-RAY?  NO  YES
- DO ANY CLOSE FAMILY/FRIENDS HAVE TUBERCULOSIS?  NO  YES
- HAVE YOU BEEN IN JAIL IN THE LAST YEAR?  NO  YES
- HAVE YOU RECENTLY HAD FEVER, NIGHT SWEATS, COUGH OR LOST WEIGHT WITHOUT TRYING?  NO  YES

**SOCIAL HISTORY**

- ARE YOU A VICTIM OF VIOLENCE/ABUSE?  NO, NEVER  YES, NOW  YES, IN THE PAST
- DO YOU SMOKE?  NO, NEVER  YES, NOW  YES, IN THE PAST AMOUNT \_\_\_\_\_
- DO YOU DRINK ALCOHOL?  NO, NEVER  YES, NOW  YES, IN THE PAST AMOUNT \_\_\_\_\_
- DO YOU USE ANY OTHER DRUGS?  NO, NEVER  YES, NOW  YES, IN THE PAST AMOUNT \_\_\_\_\_

**SEXUAL HISTORY**

YOUR RESPONSES WILL HELP US ASSESS YOUR RISK FOR SEXUALLY TRANSMITTED DISEASES AND CERVICAL CANCER

- HAVE YOU EVER BEEN SEXUALLY ACTIVE?  YES  NO (SKIP TO END)
- AGE AT FIRST INTERCOURSE: \_\_\_\_\_ NUMBER OF LIFETIME PARTNERS: \_\_\_\_\_
- ARE YOU SEXUALLY ACTIVE NOW?  NO  YES (VAGINAL)  YES (ANAL)  YES (ORAL)  OTHER \_\_\_\_\_
- HAVE YOU HAD MORE THAN ONE OR A NEW SEXUAL PARTNER IN THE PAST YEAR?  YES  NO
- DO YOU HAVE SEX WITH:  MALES  FEMALES  BOTH MALES AND FEMALES
- HAS YOUR PARTNER HAD SEX WITH:  MALES  FEMALES  BOTH MALES AND FEMALES  DON'T KNOW
- DO YOU TAKE PRECAUTIONS AGAINST SEXUALLY TRANSMITTED INFECTIONS (STIs)?  YES  NO
- HAVE ANY OF YOUR PARTNERS PUT YOU AT RISK FOR STIs OR HIV?  YES  NO  DON'T KNOW
- HAVE YOU EVER HAD SEX WHEN YOU DIDN'T WANT TO?  YES  NO
- DO YOU WANT TO BE TESTED FOR STIs OR HIV?  YES  NO  DON'T KNOW

**CONTRACEPTIVE HISTORY**

CHECK ALL OF THE BIRTH CONTROL METHODS YOU HAVE USED:

- |                                   |                                    |  |   |
|-----------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> PILL     | <input type="checkbox"/> CONDOMS   | <input type="checkbox"/> NUVARING              | <input type="checkbox"/> NATURAL FAMILY PLANNING (RHYTHM) |
| <input type="checkbox"/> DEPO     | <input type="checkbox"/> PATCH     | <input type="checkbox"/> WITHDRAWAL            | <input type="checkbox"/> STERILIZATION                    |
| <input type="checkbox"/> NORPLANT | <input type="checkbox"/> DIAPHRAGM | <input type="checkbox"/> SUPPOSITORY/FOAM/FILM | <input type="checkbox"/> OTHER _____                      |
| <input type="checkbox"/> IUD      | <input type="checkbox"/> SPONGE    |  |   |

- DO YOU AND YOUR PARTNER USE BIRTH CONTROL NOW?  NO  YES SPECIFY \_\_\_\_\_
- HOW LONG HAVE YOU USED THIS METHOD? SPECIFY \_\_\_\_\_
- HAVE YOU HAD PROBLEMS WITH THIS OR ANY BIRTH CONTROL METHOD?  NO  YES DESCRIBE \_\_\_\_\_
- DO YOU PLAN TO GET PREGNANT IN THE NEXT YEAR?  NO  YES
- DO YOU WANT A BIRTH CONTROL METHOD TODAY?  NO  YES SPECIFY \_\_\_\_\_

**WOMEN'S HEALTH HISTORY (WOMEN ONLY)**

WHEN WAS THE FIRST DAY OF YOUR LAST PERIOD?

YOUR AGE WHEN PERIOD STARTED:  DO YOU HAVE SPOTTING IN BETWEEN YOUR PERIODS?  YES  NO

PERIODS ARE:  REGULAR  IRREGULAR  PAINFUL  LIGHT  MODERATE  HEAVY

PERIODS COME EVERY \_\_\_\_\_ DAYS AND LAST \_\_\_\_\_ DAYS DO YOU HAVE PAIN WITH INTERCOURSE?  YES  NO

DATE OF YOUR LAST PAP SMEAR:    HAVE YOU HAD ANY ABNORMAL PAP SMEARS?  YES  NO

DATE OF ABNORMAL PAP SMEARS:    DATE OF LAST MAMMOGRAM:

YOUR SIGNATURE: \_\_\_\_\_

DATE: