

| D. Social History | | Have you experienced: | |
|-------------------|----|-----------------------|---|
| Yes | No | | |
| | | 43 | Has anyone close to you – hit, slapped, kicked or hurt you? |
| | | 44 | Has anyone forced you to have sex? |
| | | 45 | Has there ever been a physical cause for a spontaneous abortion? |
| | | 46 | Are you in a relationship now with someone you are afraid of? |
| | | 47 | Would you say you were ever sexually abused as a child? |
| | | 48 | If yes, have you had counseling? |
| | | 49 | Have you ever been physically abused, either recently or in the past? |
| | | 50 | Who helps and supports you with your problems? |
| | | 51 | Have you been feeling depressed or non-social? |
| | | 52 | Have you experienced any hardships or difficulties lately? If so, what? |

| E. Pregnancy History | | Yes | No | |
|----------------------|--|-----|----|---|
| | | | | 53 Have you ever been pregnant (If No, skip to Section F) |
| | | | | 54 Desires future pregnancy |
| | | | | 55 Currently pregnant |
| | | | | 56 Do you have a history of gestational diabetes? |
| | | | | 57 Do you have a history of toxemia? |
| | | | | 58 Have you had to have your cervix tied to help you carry a previous baby? |
| | | | | 59 Were your pregnancies planned? (if previously pregnant) |
| | | | | 60 Were you hospitalized during any of your pregnancy? |
| | | | | 61 Have you had any children with birth defects? |

| 62. Delivery | | | | |
|--------------|-----|------|-----------|--------------|
| Mo. | Yr. | Vag. | C-section | Birth Weight |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| 63. Abortion/Miscarriage | | | |
|--------------------------|-----|--------|---------|
| Mo. | Yr. | Spont. | Induced |
| | | | |
| | | | |
| | | | |

| F. Genitourinary History | | Yes | No | |
|--------------------------|--|-----|----|--|
| | | | | 64 Bladder or kidney problems |
| | | | | 65 Uterine fibroids |
| | | | | 66 Ovarian cysts |
| | | | | 67 Breast lump or nipple discharge |
| | | | | 68 Vaginal discharge that itches/burns or has a bad odor |
| | | | | 69 Endometriosis |
| | | | | 70 Pain with Sex |
| | | | | 71 Last pap smear, When? |
| | | | | 72 Previous abnormal pap. When? |
| | | | | 73 Colposcopy for abnormal pap. When? |
| | | | | 74 Did your mother take DES when she was pregnant with you to prevent a miscarriage? |
| | | | | 75 Do you douche? |

| G. Menstrual History | | Yes | No | |
|----------------------|--|-----|----|--|
| | | | | 76 Age periods began. |
| | | | | 77 Number of pads/tampons used on heaviest day. |
| | | | | 78 Length of period (days) |
| | | | | 79 Are your periods usually regular |
| | | | | 80 Last menstrual period started on? |
| | | | | 81 Was your last period normal? |
| | | | | 82 Do you have vaginal bleeding between periods? |
| | | | | 83 Do you have any symptoms before or with your periods? If yes, what? |
| | | | | 84 Do you have vaginal bleeding after sex? |

| H. Contraceptive History | | Yes | No | |
|--------------------------|--|-----|----|---|
| | | | | 85 Are you currently using a birth control method? If yes, what and how long? |
| | | | | 86 Any problems with this method? If yes, what? |
| | | | | 87 Do you want to use a method currently, if so what? |

| Which of the following methods have you used in the past? | | | |
|---|----|--------|---------------------|
| Yes | No | Method | When? |
| | | 88 | Abstinence |
| | | 89 | Sterilization |
| | | 90 | Oral Contraceptives |
| | | 91 | Norplant/Implanon |
| | | 92 | Depo-Provera |
| | | 93 | Lunelle |
| | | 94 | IUD |
| | | 95 | Condoms |
| | | 96 | Diaphragm/Cap |
| | | 97 | Sponge |
| | | 98 | Withdrawal |
| | | 99 | Patch/Ring |
| | | 100 | Condoms/Spermicide |

| I. HIV/STI Risk | | Yes | No | |
|-----------------|--|-----|----|---|
| | | | | 101 Have you ever had sex? |
| | | | | 102 If yes, your age when you first had sex. |
| | | | | 103 If yes, how many partners have you had in your life? Male _____ Female _____ |
| | | | | 104 If yes, how many partners in the past year? Male _____ Female _____ |
| | | | | 105 If yes, have you ever had any problems related to sexual function? If yes, what? |
| | | | | 106 Are you currently sexually active now? |
| | | | | 107 History of sexually transmitted infections? If yes, check all that apply. O Chlamydia O Gonorrhea O Syphilis O Trich O Genital Warts O Genital Herpes O PID |
| | | | | 108 Have you ever had unprotected vaginal, oral or anal sex with a partner whose HIV status was unknown to you or positive for HIV/STIs? |
| | | | | 109 Have you ever been exposed to any semen, blood or vaginal discharge from a person whose HIV status was unknown to you or positive for HIV? |
| | | | | 110 Do you frequently use alcohol, cocaine or other drugs in connection with sexual activity? |
| | | | | 111 Have you ever taken street drugs? When? |
| | | | | 112 Have you ever had any needle sticks with unknown or unclean needles? |
| | | | | 113 Have you had a blood transfusion in the US from 1978-1985, or foreign country since 1978? |
| | | | | 114 Have you had artificial insemination using untested donor semen since 1978? |
| | | | | 115 Do you use condoms regularly during sex? |
| | | | | 116 Are you a hemophiliac, or have you had sex with a hemophiliac (1978-1985)? |

Patient Sticker

Thank you for answering these questions. If anything above is unclear, please ask your provider to explain it to you.

I understand that my decision not to complete this form will not result in prejudice to my future medical care or in withdrawal or withholding or any benefits provided by programs or projects receiving federal funds to which I may otherwise be entitled.

| J. General Medical Questions | | |
|--|----|--|
| Yes | No | |
| | | 117 Are you currently taking any medications? If yes, what kind? |
| | | 118 Do you faint or have any reaction to having blood drawn? |
| | | 119 Are you planning a pregnancy within the next year? |
| | | 120 Are you experiencing any problems today? If yes, what kind? |
| K. Today's Visit | | |
| 121 What is the purpose of your visit today? | | |
| 122 May we help you in any other way? | | |
| L. Patient Comments | | |
| | | |
| M. Patient and Employee Signature | | |
| ALL SERVICES AT FPHC ARE CONFIDENTIAL. HOWEVER, IF YOU ARE A MINOR, IT IS REQUIRED THAT A REPORT BE FILED WITH LEGAL AUTHORITIES IN THE CASE OF ABUSE | | |
| To the best of my knowledge, the information I have provided is correct and complete. | | |
| _____ | | _____ |
| Patient Signature | | Date |
| _____ | | _____ |
| Staff Signature | | Date |
| Patient Sticker | | |

| Employee Comments | |
|-------------------|----------|
| Number | Comments |
| | |