Portsmouth City Health Department
Connecting with Community

MEDICAL HISTORY

PATIENT NAME _____**PHARMACY**_____**DOB** _____**AGE:**____

PAST OR PRESENT ILLNESS (circle all that apply):
☐NONE ☐OTHER_____
Diabetes Asthma Hepatitis (B or C) Cancer
Heart Disease Thyroid Disorder Anemia
Liver Disease Kidney Disease Blood Clotting Disorder
Depression Anxiety High Blood Pressure
High Cholesterol Seizure Disorder

FAMILY HISTORY (Diabetes, Heart Disease, etc):

Relative	Diagnosis	Age
(Example)Mother	Diabetes	40

MEDICATION(S):
Medication Allergies: ☐NONE ☐SEE LIST
_____
Current Medications & Prescribing Doctor: ☐NONE
_____
_____

Immunizations

Rubella Vaccine	☐Yes	☐No	☐Not Sure
Hepatitis B Vaccine Series	☐Yes	☐No	☐Not Sure
Gardasil (HPV) Series	☐Yes	☐No	☐Not Sure
Flu Shot (this year)	☐Yes	☐No	☐Not Sure

Emotional History
When you feel sad do you…
☐ bounce back quickly
☐ feel sad for 2 weeks or more
How often do you feel nervous, anxious or worried?
☐Daily ☐Weekly ☐Monthly ☐Seasonal

SURGERIES (Please include year): ☐NONE
_____
_____

LIFESTYLE/RISK FACTORS:
Alcohol? ☐ Less than 2 beers per day
☐ More than 2 beers per day ☐ None
Condom Use? ☐ No ☐ Occasionally ☐ Yes
Diet? ☐Balanced ☐ Overeating ☐ Undereating
Current drug Use? ☐Heroin ☐Inhaled ☐Marijuana
☐Other(s) ☐Downers ☐Uppers ☐ None
Is your partner(s) an IV drug user? ☐ Yes ☐ No
Last menstrual period? _____ ☐Male
Physical Activity/Exercise?
☐Mild Exercise ☐Occasional Vigorous Exercise
☐Regular Vigorous Exercise ☐Sedentary (no exercise)
Have you ever been sexually active? ☐ Yes ☐ No
Are you currently sexually active? ☐ Yes ☐ No
Number of Partners in the last year? _____
Have you ever had a Sexually Transmitted infection?
☐ Yes ☐ No
If so, what? ☐ Chlamydia ☐ Trichomonas
☐Herpes ☐ Gonorrhea ☐ Syphilis ☐ HIV
Tobacco Use?
☐ Current User: Packs per day _____
☐ Decreasing Tobacco ☐ Never ☐ Recently Quit

Social History

☐Yes ☐No	Are you adopted?
☐Yes ☐No	Someone hits, slaps, kicks, or hurts you?
☐Yes ☐No	Someone who often says hurtful or mean things?
☐Yes ☐No	Afraid of your partner(s)/other
☐Yes ☐No	Alcohol and/or drug problems in your life?
☐Yes ☐No	Are others concerned about your alcohol/drug habits?
☐Yes ☐No	Parents aware of your visit today?

PLEASE CONTINUE ON REVERSE SIDE→

Pregnancy History

☐*NO PREGNANCY (SKIP THIS BOX)*

Live Births ____**Date(s)** _____
Premature Births ____**Date(s)** _____
Tubal Pregnancies Births ____**Date(s)** _____
Abortions ____**Date(s)** _____
Living Children ____**Date(s)** _____
C-Sections ____**Date(s)** _____
Miscarriage(s) ____**Date(s)** _____

Please mark if you have had any of the following problems with any pregnancy with you or in your immediate family:

☐Gestational Diabetes ☐Genetic Abnormalities
☐High Blood Pressure ☐Preterm Labor
☐Two or more miscarriages ☐Stillborn
☐Baby with heart defect
☐Baby born too soon or weighing less than 5 ½ pounds

Males Only

☐Yes ☐No Do you perform self testicular exams?
☐Yes ☐No Have you had a vasectomy/sterilization?

Sexual History

Age when you first had sex? _____
How many times _____month/year are you having sex?

Have you ever been sexually abused/raped?
☐Yes ☐No
Does your partner have sex with both male and female? ☐Yes ☐No, only (circle) men / women
Are you and your partner **only** with each other?
☐Yes ☐No
Is it a committed, stable and safe relationship?
☐Yes ☐No

What is your sexual orientation (preference)?
☐Lesbian, gay or homosexual
☐Straight or heterosexual
☐Bisexual
☐Something else
☐Don't know

What do you associate yourself as (identity)?
☐Male
☐Female
☐Transgender
☐Genderqueer (neither male or female)

Females Only

Menstrual Cycle

First day of your last period: _____
Was your last period normal? _____
Age when period started: _____
Periods come every_____days
Bleeding lasts_____days
Periods are: ☐Regular ☐Irregular ☐Painful
Flow is: ☐Light ☐Normal ☐Heavy

Pap History

Last Pap smear: _____
Was it normal? _____
Have you ever had an abnormal pap smear? ☐Yes ☐No
If so, when? _____
Did you receive any treatment? _____

Breast Exam

Do you do Self Breast Exam? ☐Yes ☐No

Birth Control

Current form of birth control:_____
Any side effects?_____
Other forms of birth control used in the past:
_____
Any side effects? _____

Reproductive Life Plan

Have you ever been pregnant? ☐Yes ☐No
Do you have plans for future pregnancy? ☐Yes ☐No
If yes, how many? _____
At what age would you like to have children? _____
How far apart would you like your children to be? ____
If you where pregnant would you be happy
☐Yes ☐No
Would it be difficult for you to support a child currently?
☐Yes ☐No
What will you do if you become pregnant?
_____

PATIENT SIGNATURE _____**DATE:**_____

PATIENT NAME (PLEASE PRINT) _____