Patient Identification

Today's date:____/____/_____ Birth date:____/____/_____

Client name: _____ Age: _____

List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: _____

Nutritional History

Yes **No** Are there changes you would like to make to your diet? If yes, describe: _____

Yes **No** Do you exercise regularly? Describe: _____

List any supplements, herbs, or weight loss products you use:

_____

Immunizations (list dates)

Yes **No** Measles, mumps, rubella (MMR) _____

Yes **No** Tetanus, diphtheria, pertussis (Tdap) _____

Yes **No** Hepatitis A _____

Yes **No** Hepatitis B _____

Yes **No** Varicella (chicken pox) _____

Yes **No** HPV (Human Papillomavirus) _____

Yes **No** Influenza (Flu) _____

Your Family History

☐ Check here is you do not know your family history.

Have your grandparents, parents, or brothers/sisters had any of the following? If yes, list who and at what age.

Yes **No** Blood clots in arms/legs/chest _____

Yes **No** Bleeding problems _____

Yes **No** High blood pressure (hypertension) _____

Yes **No** High cholesterol/triglycerides _____

Yes **No** Breast/ovarian/uterine/colon cancer _____

Yes **No** Heart attack _____

Yes **No** Stroke _____

Yes **No** Diabetes _____

Yes **No** Birth defects _____

Yes **No** Alcohol/drug misuse or abuse _____

Your Medical History

Do you have now or have you had any of the following?

Yes **No** Are you taking any prescription or over the counter medicines? Please list: _____

Yes **No** Have you been to the ER or hospitalized in the last year? Please list: _____

Yes **No** Asthma

Yes **No** Heart disease or high blood pressure (hypertension)

Yes **No** Heart attack or stroke

Yes **No** High cholesterol/triglycerides

Yes **No** Migraines or frequent headaches

Please describe: _____

Yes **No** Visual changes or numbness

Yes **No** Lupus (SLE)

Yes **No** Cancer

Please list type and year diagnosed: _____

Yes **No** Blood problems (Sickle cell anemia, hemophilia, low iron)

Yes **No** Have you or your partner(s) ever had a blood transfusion, tissue/organ transplant, or artificial insemination?

Yes **No** Inflammatory bowel disease (IBD)

Yes **No** Gall bladder disease

Yes **No** Surgery Please list: _____

Yes **No** Breast disease

Yes **No** Mammogram Date of last mammogram: _____/__/_____

Your Medical History Continued

Yes **No** Kidney or bladder problems

Yes **No** Liver disease (hepatitis, mono, jaundice, cirrhosis)

Yes **No** Diabetes

Yes **No** Epilepsy, seizures or convulsions

Yes **No** Depression or other mental health concerns

Yes **No** Have you had gender affirming surgery?

Your Sexual and Reproductive Health

Have you ever had any of the following sexually transmitted infections:

Yes **No** Chlamydia

Yes **No** Gonorrhea

Yes **No** Genital warts/Human Papillomavirus (HPV)

Yes **No** Syphilis

Yes **No** Herpes

Yes **No** Trichomoniasis

Yes **No** Non-gonococcal urethritis (NGU)

Yes **No** Have you or your sexual partner(s) ever used needles to shoot drugs?

Yes **No** Have you or your sexual partner(s) ever exchanged sex for drugs or money?

Yes **No** Do you use condoms (either external or internal) If yes, how often: Never Sometimes Always

Yes **No** Have you ever been tested for HIV? When? _____

Yes **No** Have you had a positive HIV test result?

Yes **No** Have you had a new partner in the past 2 months?

Yes **No** How many lifetime sexual partners have you had? # _____

Yes **No** Are your sex partners: male ____ female ____ both ____ transgender ____ transsexual ____ intersex ____ non-binary ____ other ____

Yes **No** Do you have vaginal sex?

Yes **No** Do you have oral sex? Circle all that apply. Receive/Bottom Give/Top

Yes **No** Do you have anal sex? Circle all that apply. Insertive/Top Receptive/Bottom Both

Yes **No** When was the last time you have sex? _____

Yes **No** Have any male partners had sex with other men?

Yes **No** Are any of your sex partners living with HIV?

Yes **No** Do you have a trusted adult to talk to about things like healthy relationships, sex, and birth control?

Yes **No** Has a partner ever forced you to do something sexually that you did not want to do or refused your request to use condoms?

Yes **No** Does your partner support your decision about when or if you want to become pregnant?

*Complete these questions <u>only</u> if you are **male**, **assigned male at birth**, or (male to female) **MTF***

Your Urological History

Yes **No** Do you have abnormal discharge from the penis?

Yes **No** Do you have now or in the past a lesion, sore, or lump on your penis, scrotum or testicles?

Yes **No** Have you ever had pain with sex? When: _____

Your Reproductive History

Yes **No** How many children do you have? _____

Yes **No** Do you think you might want to have (more) Children at some point?

Yes **No** When do you think that might be? _____ How important is it to you to prevent pregnancy?

_____

Yes **No** Are you using birth control? If so, which method are you using:

Client name: _____

*Complete these questions <u>only</u> if you are **female, assigned female at birth**, or female to male (**FTM**)*

<u>Your Menstrual History</u>

Please share the date of your last menstrual period (first day):
____/____/____

Yes **No** Was your last menstrual period normal?
Yes **No** Do you have a period every month?
Is the flow: light_____ medium_____ heavy_____
Yes **No** Do you bleed between periods?
Yes **No** Do you have cramps with your periods?
Yes **No** Do you take medication for cramps? What type:_____
Yes **No** How old were you when you had your first period? _____

<u>Your Pregnancy History</u>

How many times have you been pregnant? _____
List the dates that you gave birth: _____
_____
How many living children do you have? _____
List the dates of any miscarriages or abortions: _____
List the dates of any tubal pregnancies: _____
Yes **No** Are you breastfeeding now?
Yes **No** Have you had a baby that weighed less than 5 ½ pounds?
Yes **No** Have you had a baby that weighed more than 9 pounds?
Yes **No** During any pregnancy, did you have high blood pressure, diabetes, or a baby with birth defects?

<u>Your Gynecological History</u>

When was your last Pap or HPV screening done? _____
Have you had any of the following?
Yes **No** Abnormal Pap or HPV result? If yes, when? _____
Yes **No** Colposcopy, biopsy or treatment of your cervix?
If yes, when? _____
Yes **No** Ovary problems
Yes **No** Uterus problems or uterine fibroids?
Yes **No** Pelvic Inflammatory Disease (PID)
Yes **No** Pain or other problems with sex
Yes **No** Vaginal infections (yeast or bacterial)

<u>Your Birth Control History</u>

Yes **No** Do you think you might want to have (more) children at some point?
Yes **No** When do you think that might be? _____
Yes **No** How important is it to you to prevent pregnancy?
_____
Yes **No** Are you using a method of birth control now?
If yes, what method? _____
Yes **No** Have you used a birth control method that you had a problem with? Please describe: _____
_____
Yes **No** In the last 5 days or since your last period, have you had sex without birth control or did your method of birth control fail (condoms are birth control)?

Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things
0 1 2 3
Feeling down, depressed or hopeless
0 1 2 3

**PHQ-2*

Yes **No** Have you been hit, punched, or otherwise hurt by someone within the past year? If so, by whom?
_____
Yes **No** Do you feel safe in your current relationship?
Yes **No** Is there a partner from a previous relationship who is making you feel unsafe now?

**PVS*

Yes **No** Have you ever been emotionally or physically abused by your partner or someone important to you?

Yes **No** Within the last year, have you ever been hit, slapped, kicked, or otherwise physically hurt by someone? If YES, who? (circle all that apply)
Partner Ex-Partner Stranger Other Multiple
Total # of times: _____

Yes **No** Within the last year, has anyone forced you to have sexual activities? If YES, who? (circle all that apply)
Partner Ex-Partner Stranger Other Multiple
Total # of times: _____

Yes **No** Are you afraid of your partner or anyone listed above?

<u>Answer the following question only if you are currently pregnant</u>:

Yes **No** Since you've been pregnant, have you been slapped, kicked, or otherwise physically hurt by someone? If YES, who? (circle all that apply)
Partner Ex-Partner Stranger Other Multiple

**AAS (Please use AAS-D as needed)*

Client name: _____

Please answer these questions if you are under the age of 22.

During the past 12 months, did you:

Yes **No** Drink any alcohol (more than a few sips)?
Yes **No** Use any marijuana or hashish?
Yes **No** Use anything else to get high (i.e. illegal drugs, over the counter and prescription drugs, and things that you sniff or huff)?

If you answered **yes** to any of these questions above, please answer the following questions:

Yes **No** Have you ever ridden in a **car** driven by someone (including yourself) who has "high" or had been using alcohol or drugs?
Yes **No** Do you ever use alcohol or drugs to **relax**, feel better about yourself, or fit in?
Yes **No** Do you ever use alcohol or drugs while you are by yourself, or **alone**?
Yes **No** Do you ever **forget** things you did while using alcohol or drugs?
Yes **No** Do your **family** or **friends** ever tell you that you should cut down on your drinking or drug use?
Yes **No** Have you ever gotten into trouble while you were using alcohol or drugs?

**CRAFFT for adolescents*

Please answer these questions if you are over the age of 21.

In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks/day. For women, 4 or more drinks/day)

Never Once or Twice Monthly Weekly Daily or Almost Daily

Tobacco/Marijuana Products

Never Once or Twice Monthly Weekly Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons

Never Once or Twice Monthly Weekly Daily or Almost Daily

Illegal Drugs

Never Once or Twice Monthly Weekly Daily or Almost Daily

**NIDA ASSIST for adults*

Client Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____