

**Staff Use Only: Allergies** \_\_\_\_\_  
**MCIR Review**

**PERSONAL HISTORY**

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent EXCEPT as may be required by law. All clients under the age of 18 are encouraged to talk with their parents about contraception and receiving services.

Date \_\_\_\_\_ Name \_\_\_\_\_ Client ID \_\_\_\_\_ Age \_\_\_\_\_

I am here today for \_\_\_\_\_

Questions/concerns I would like to discuss \_\_\_\_\_

**Contraceptive History**

Are you currently using birth control? Y N If yes what method? \_\_\_\_\_

Are you highly satisfied with your birth control method? Y N

Are you having problems with your birth control? Y N If yes what? \_\_\_\_\_

What other birth control have you used in the past? \_\_\_\_\_

Why did you stop using the other birth control? \_\_\_\_\_

What method would you like today? \_\_\_\_\_

**Medical History**

Do you have a Doctor/ Clinic that you go to? Yes No Name of doctor/Clinic \_\_\_\_\_

Are you taking any medications? (prescribed, over the counter, supplements) Yes No What? \_\_\_\_\_

Do you have any allergies? (Medications, food, latex, metal) List allergies \_\_\_\_\_

List any hospitalizations, surgery or serious illness in the past year \_\_\_\_\_

Are you immunized (had your shots) for:

Rubella (German measles): Yes No Hepatitis B: Yes No Gardasil (HPV): Yes No

How often do you:

Exercise \_\_\_\_\_ Use Alcohol \_\_\_\_\_ Use Recreational Drugs \_\_\_\_\_

Do you smoke/vape? Yes No

If Yes: What do you smoke/vape? \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

How many/how often per day? \_\_\_\_\_

Do you want to quit? Yes No

YES	NO	HAVE YOU HAD	COMMENTS
		Seizures/fainting/Neurological Disorders	
		Emotional Problems/Depression	
		Thyroid Problems	
		Breast Disease/ Lump/ Nipple Discharge	
		Breast or Ovarian Cancer	
		Chest Pain/Difficulty Breathing/Asthma	
		Heart Problems/Murmurs/High Blood Pressure	
		High Cholesterol	
		Blood Clots/Stroke/Varicose Veins	
		Anemia/ Blood Disorders	
		Diabetes	
		Hepatitis, Liver, or Gall Bladder Disease	
		Stomach/ Intestinal Problems	
		Kidney or Bladder Problems	
		Other Cancer	
		Migraine Headaches with Aura (loss of vision, visual disturbances, weakness of arms/legs, slurred speech)	
		Diagnosed by healthcare provider? Yes No	

**FAMILY HISTORY: Have your parents, brothers or sisters ever had any of the following?**

Yes	No	Disease	Comments
		Heart Disease or Death from Heart attack before age 50	
		High Blood Pressure	
		Blood Clot/Stroke	
		Anemia/Blood Disorder	
		Diabetes	
		Breast or Ovarian Cancer (any relative)	
		High Cholesterol	
		Genetic Disorders/Birth Defects	
		Other Cancer	

**Sexual History**

Are you in a sexual relationship? Yes No	Age at time you became sexually active
Do you use condoms? Always Occasionally Never	
How long have you been sexually active with your current partner?	Number of partners in the past year
Has your partner had more than 1 partner in the past year? Yes No	
Do you or your partner have STI symptoms? Yes No	
Have you or your partner ever been diagnosed with: Gonorrhea Syphilis Chlamydia Herpes HPV/Warts HIV	
Have you or your partner been treated for an STI in the past year? Yes No	
Have you or your partner used drugs by needles? Yes No	
Have you or your partner ever traded sex for drugs or money? Yes No	
Who do you have sex with? Males Females Both	
Have any of your partners been bisexual? Yes No	
Do you feel pressured to have sex? Yes No	
Has anyone touched you in a way that made you feel uncomfortable? Yes No	
Have you had sex when you didn't want to? Yes No	
Do you feel you need to have sex to feel loved? Yes No	
Has anyone ever hit or hurt you? Yes No	

**Females Only**

Menstrual History	Gynecological History	Pregnancy history
Age periods began?	Last pap smear? Result?	Do you think you may be Pregnant now? Y N
First day of last period? Month Day	Ever had Abnormal Pap Smear? Y N If Yes, when?	Number of Pregnancies? Number of Live Births?
Any unusual/missed periods last year? Y N	Any unusual discharge, odor, itching, sores, rashes or bumps vaginally? Y N	Number of miscarriages? Number of terminations?
How many days do you bleed?	Any pain/bleeding with sex? Y N	Complications with pregnancies? Y N
Do you have severe cramps? Y N	Any pain/burning on urination? Y N	Number of ectopic pregnancies?
Is your bleeding: Light Medium Heavy	Ever diagnosed with pelvic inflammatory disease (PID)? Y N	Are you breastfeeding now? Y N Ages of children?
Any unprotected sex since your last menstrual period? Y N	Diagnosed with uterine growths, fibroids, endometriosis, or other? Y N	Would you like to become pregnant in the next year? Y / N / Unsure / Okay either way

**Males Only**

Yes	No	Reproductive System	Comments
		Any discharge from your penis or pain/burning on urination? Y N	
		Any pain or lump in testicles? N Y	
		Have you had any treatment for a urological condition? Y N	

To the best of my knowledge, the above information is complete and accurate.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

Date: \_\_\_\_\_