Medical History

All Information is strictly confidential.

<table>
<thead>
<tr>
<th>Have you had any of the following? Answer only questions applicable to you:</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Abnormal Pap Smear</td>
<td></td>
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<tr>
<td>Colposcopy and/or Treatment</td>
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<tr>
<td>Anemia/Polythemia</td>
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<tr>
<td>Bariatric Surgery</td>
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<tr>
<td>Bleeding or Bruising Disorder</td>
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<tr>
<td>Blood Clots in vein / leg / lung</td>
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<td>Blood Transfusion</td>
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<tr>
<td>Exposure to Blood Products</td>
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<tr>
<td>Breast Disease / Breast Surgery</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Chemical Dependency</td>
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<tr>
<td>Diabetes / Gestational Diabetes</td>
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Allergies (medications, latex, iodine, metal, skin allergens etc.): ____________________________

Medications (including over the counter), vitamins, herbs or supplements you are taking: __________________________________________________________
_______________________________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________________

Have you ever been hospitalized or had surgery?  Yes    No    Explain ________________________________________________________________
_______________________________________________________________________________________________________________________________________

Are you being treated for any illness or condition now? ________________________________________________________________________________
_______________________________________________________________________________________________________________________________________

Are you now or have you in the past 3 months experienced? Please only answer questions applicable to you:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>---------</th>
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</thead>
<tbody>
<tr>
<td>Fever/Night Sweats</td>
<td>Swollen lymph nodes</td>
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<tr>
<td>Pain with ejaculation</td>
<td>Unexplained fatigue</td>
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<tr>
<td>Scrotal/Testicle pain or swelling</td>
<td>Unexplained weight loss</td>
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<tr>
<td>Skin rashes/sores/bumps</td>
<td>Urethral discharge</td>
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<tr>
<td>Sore throat</td>
<td>Urinary difficulty/pain/blood</td>
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</tbody>
</table>

History of cervical cancer screening:  N/A
When was your last pap smear? ____________________________
Was it normal?  Yes    No

Menstrual History:  N/A
1st day of your last menstrual period ____________________________
Was your last period normal and on time?  Yes    No
Age at first menses (period): ____________________________
How often do your periods come (from the first day of one period to the first day of the next)? (Ex: 28 days)  ____________________________
How many days do you bleed? ____________________________
Are your periods:  light    moderate    heavy

Obstetrical History:  N/A
- Never been pregnant (skip Obstetrical History)

List number of:
<table>
<thead>
<tr>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births/Deliveries:</td>
</tr>
<tr>
<td>Abotions:</td>
</tr>
<tr>
<td>Miscarriages:</td>
</tr>
<tr>
<td>Living Children:</td>
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</tbody>
</table>

Circle any of the complications you experienced:
- Cesarean
- Premature Birth
- Twins/Multiples
- Still Birth
- Gestational Diabetes
- Ectopic
- Genetic Abnormality

[Continued On Back]
**Family Medical History:**
Were you adopted? □ Yes □ No
**Please mark if your biological Father (F), Mother (M), Brother (B), or Sister (S) have had the following:**
□ Cancer of ovary, breast, colon or uterus
□ Heart Attack/ Stroke before age 65
□ High Blood Pressure/ High Cholesterol
□ Diabetes
□ Depression/ Mental Disorder
□ Chemical Dependency
□ Mother took DES during pregnancy
□ Other: __________________________________________

**Health Risk History:**
Do you smoke or use tobacco?
□ Yes, socially
□ Yes, every day
   How many per day? ______________________
   Do you want to quit?
□ No, former smoker. How long? ______________________
□ No, never
Do you use alcohol? □ Yes □ No
   How many times per week? ______________________
   How many drinks per occasion? ______________________
Do you use street drugs? □ Yes □ No
   Explain: ______________________________________
Do you do any form of regular exercise? □ Yes □ No
   What? ______________________
   How often? ______________________
Do you wear a seatbelt?
□ Never □ Sometimes □ Always
Do you perform self-breast exams? □ Yes □ No
   How often?: ______________________
Do you perform self-testicular exams? □ Yes □ No
   How often?: ______________________

**Contraceptive History:** □ N/A
Are you currently using any method of birth control, including condoms? □ Yes □ No
If no, check: □ Abstinent □ Female partner □ Trying to get pregnant
What method are you using? ______________________
How long have you used this method? ______________________
Are you having any problems with this method? □ Yes □ No
   Explain: ______________________________________
Do you want to continue your current method? □ Yes □ No
   If no, what do you want to switch to? ______________________
   Explain any problems: ______________________________________
Are you planning a pregnancy in the next year?
□ Yes □ No
Are you concerned you could be pregnant now?
□ Yes □ No
Do you have any questions or concerns about sex that you would like to discuss? □ Yes □ No
   Explain: ______________________________________
   ______________________________________

**Sexual History:**
Are you currently sexually active? □ Yes □ No □ Never
   □ Vaginal □ Oral □ Anal
Are you partners: □ Male □ Female □ Both
Do you practice safe sex to protect against sexually transmitted infections (ex: condoms, dental dams)?
□ Never □ Occasionally □ Always
Do you want to be tested for sexually transmitted infections?
□ Yes □ No
Have you been exposed to any infectious disease?
□ Yes □ No
Do you have a history of any sexually transmitted infections?
□ Chlamydia □ PID □ Trichomonas
□ Gonorrhea □ HIV □ Genital Herpes
□ Syphilis □ Hep B □ HPV/Genital Warts
□ Other: ______________________________________
Number of sexual partners within the past 12 months? _______
Number of NEW sexual partners within past 3 months? _______

**Safety:**
Have you or any sexual partner ever used IV drugs or shared needles (including drug needles, piercing or tattoos)?
□ Yes □ No
Has your partner or a family member ever hit, punched, kicked, or physically hurt you or threatened to hurt you?
□ Yes □ No
Do you feel safe in your relationship and in your home?
□ Yes □ No
Have you ever been forced to have sex/do something sexual, or been touched against your will?
□ Yes □ No
If yes, have you had counseling?
□ Yes □ No

***To the best of my knowledge this information is complete and correct***