



Place patient label here.

District 3 Patient Self-History Form

Are you allergic to any foods or medications? Yes No

If yes, please list the name and reaction? _____

List all of the medications that you are currently taking (including birth control, herbs and over the counter medications):

Do you have a Primary Care Physician (PCP) or a place where you receive routine medical care? Yes No

Are you currently being treated for an illness? No Yes _____

Circle Y for "Yes" or N for "No." If you are unsure about any question, leave blank and ask the nurse for help. Family history includes your mother, father, grandparents on both sides, aunts, uncles, and brothers and sisters (only blood related).

Medical History: Circle those that apply, Y for yes or N for no	YOU	FAMILY	NURSING COMMENTS
Birth Defects	Y or N	Y or N	
Breast	Y or N	Y or N	
Cancer	Y or N	Y or N	
Communicable Disease (HIV/Measles/Varicella)	Y or N	Y or N	
Dermatologic (Acne/Eczema/Psoriasis)	Y or N	Y or N	
Ear/Nose/Throat/Mouth	Y or N	Y or N	
Gastrointestinal Disorders	Y or N	Y or N	
Genetic Disorders (Down's Syndrome/Sickle Cell)	Y or N	Y or N	
Genitourinary Disorders (Frequent UTIs, Ovarian Cysts, Uterine Fibroids, etc.)	Y or N	Y or N	
Hearing Problems	Y or N	Y or N	
Heart Disease (Hypertension/Stroke/Heart Attack/Murmur)	Y or N	Y or N	
Hematologic (Anemia/Blood Clots/Blood Transfusions)	Y or N	Y or N	
Hepatobiliary Disorders (Liver Disease/Hepatitis/Gallbladder Disease/Pancreatitis)	Y or N	Y or N	
Hospitalizations/Emergency Room Visits/Surgeries	Y or N		
Infectious Disease	Y or N	Y or N	
Kidney Disease	Y or N	Y or N	
Lung Disease(Asthma/Chronic Bronchitis/COPD/Tuberculosis (TB))	Y or N	Y or N	
Metabolic/Endocrine (Diabetes/Thyroid Problems)	Y or N	Y or N	
Musculoskeletal (Arthritis/Gout/Osteoporosis)	Y or N	Y or N	
Neurologic (Seizures/Migraines)	Y or N	Y or N	
Overweight/Obesity	Y or N	Y or N	
Oral Cavity Disorders (Implants/Ulcers/Cavities)	Y or N	Y or N	
Psychological Disorders (Depression/Bipolar Disorder/Anxiety/Suicidal Thoughts)	Y or N	Y or N	
Reproductive (total # of pregnancies_____, # full-term_____, # premature_____, # stillborn_____, # of abortions_____, # of miscarriages _____)	Y or N		
Rheumatological (Lupus/Rheumatoid Arthritis)	Y or N	Y or N	
Sexually Transmitted Diseases (STDs)	Y or N		
Vision Problems (Cataracts/Glaucoma/Glasses/Contacts)	Y or N	Y or N	

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District 3 Patient Self-History Form

Do you drink alcohol? Y or N If yes, what type? _____ Amount: _____ Frequency: _____	Have you ever been hit, kicked, shoved or had things thrown at you by your partner? Y or N
Do you use drugs? Y or N If yes, what type? _____ Amount: _____ Frequency: _____	Have you ever been forced by anyone to have intercourse or any form of sexual contact against your will? (when you have said or wanted to say no) Y or N
What was the last grade you completed in school? _____	Have you or your children ever been afraid / threatened by your partner / boyfriend? Y or N
Do you work? (circle one) Full-time Part-time Unemployed Student Other _____ Occupation: _____	What is your marital status? (circle one) Divorced Living with Partner Married Single Widowed
Have you ever been incarcerated (jail or prison)? Y or N	Do you ever feel like hurting yourself? Y or N
Are you currently on parole? Y or N	Have you ever used a needle to inject drugs? Y or N
Who do you live with? _____	Have you ever exchanged sex for drugs or money? Y or N
Do you smoke, chew or dip tobacco? Y or N If yes, how much per day? _____	Have you ever had sex while using non-injected drugs? Y or N
Have you ever smoked tobacco and quit? Y or N	Women only: What age did your menstrual periods begin? _____ When did your last period start? _____ How many days did it last? _____ Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ Any period problems? _____ Painful periods that require medication? _____ Do you douche? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have vaginal discharge or odor? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you examine your breasts? Y or N How often? _____ Any breast problems? _____ Date of your last pelvic exam: _____ Date of your last pap smear: _____ Have you ever had an abnormal pap smear? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of your last mammogram: _____ Date of your last colorectal screening test: _____ Date your last pregnancy ended: _____ Are you breast feeding now? <input type="checkbox"/> Yes <input type="checkbox"/> No Did your mother take DES (diethylstilbestrol) when she was pregnant with you (if born before 1972)? Y or N Did you have any problems with any pregnancies? Y or N
Men and Women: Age at first intercourse? _____ Date of last intercourse: _____ # of partners in the last year? _____ Any new partners in the last 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No # of partners in last 60 days? _____ Do you use condoms every time that you have sex? Y or N Do you have sex with? <input type="checkbox"/> Men only <input type="checkbox"/> Women only <input type="checkbox"/> Both Men and Women Last HIV test date: _____ Last HIV result: _____ Does your partner(s) have any problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Check all the ways you have sex: <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Anal What do you use for birth control? (check all that apply) <input type="checkbox"/> Male Condoms <input type="checkbox"/> Female Condoms <input type="checkbox"/> Diaphragm <input type="checkbox"/> Pills <input type="checkbox"/> Foam/Gel <input type="checkbox"/> Patch <input type="checkbox"/> Depo <input type="checkbox"/> Implant <input type="checkbox"/> IUD <input type="checkbox"/> Abstain <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Withdrawal/Pull Out <input type="checkbox"/> None <input type="checkbox"/> Other _____ Are you satisfied with the method? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which method(s) do you wish? _____ Do you or your partner want to become pregnant? Y or N If yes, when? _____ What is your present health status? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Have you received dental care in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Men only: Have you been circumcised? Y or N Do you have any problems with testicles or scrotum (lumps, pain, swelling)? Y or N Do you perform testicular self-exams? Y or N Have you ever been involved in a pregnancy or fathered a child? Y or N