





<b>Sex</b>	Are you sexually active	yes	no
	Sexual Preference	M	F
	If yes, are you trying for a pregnancy	yes	no
	If not, list contraceptive method used	yes	no
	Any discomfort with intercourse	yes	no
	Illness related to the HIV, such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use & unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness	yes	no
		yes	no
<b>Personal Safety</b>	Do you live alone	yes	no
	Do you have frequent falls	yes	no
	Do you have vision or hearing loss	yes	no
	Do you have an Advance Directive and/or Living Will?	yes	no
	Would you like information on the preparation of these?	yes	no
		yes	no
	Physical and/or mental abuses have also become major public health issues in this country. This often takes the form of verbally threatening behavior and/or actual physical /sexual abuse. Would you like to discuss this issue with your provider	yes	no

## FAMILY HEALTH HISTORY

		Age	Age@ Death	Significant Health Issues or Cause of Death
<b>Father</b>				
<b>Mother</b>				
<b>Siblings</b>	M F			
	M F			
	M F			
	M F			
<b>Children</b>	M F			
	M F			
	M F			
	M F			
<b>Grandparents (Father's side)</b>				
	<b>Grand Father</b>			
	<b>Grand Mother</b>			
<b>Grandparents (Mother's side)</b>				
	<b>Grand Father</b>			
	<b>Grand Mother</b>			

## MENTAL HEALTH

Is stress a major problem for you	yes	no
Do you feel depressed	yes	no
Do you panic when stressed	yes	no
Do you have problems with eating or your appetite	yes	no
Do you cry frequently	yes	no
Have you ever attempted suicide	yes	no
Have you ever seriously thought about hurting yourself	yes	no
Do you have trouble sleeping	yes	no
Have you ever been to a psychologist/counselor	yes	no

## WOMEN ONLY

Age at onset menstruation		
Date of last menstruation		
Period every ( ) # of days. Heavy periods, irregularity, spotting, pain or discharge		
( ) # of pregnancies. ( ) # of live births		
Are you currently pregnant or breastfeeding	yes	no
Have you had D&C, hysterectomy, or Cesarean section	yes	no
Any urinary tract, bladder, or kidney infections within last year	yes	no
Any blood in your urine	yes	no
Any problems with control of urination	yes	no
Any hot flashes or sweating at night	yes	no
Do you have menstrual tension, pain bloating, irritability, or other symptoms at or around time of period	yes	no
Experienced any recent breast tenderness, lumps, or nipple discharges	yes	no
Date of last pap smear and rectal exam?	yes	no

## MEN ONLY

Do you usually get up to urinate during the night If yes, ( ) # of times	yes	no
Do you feel pain or burning with urination		
Any blood in your urination		
Do you feel burning discharge from penis	yes	no
Has the force of your urination decreased	yes	no
Have you had any kidney, bladder, or prostate infections within the last 12 months	yes	no
Do you have any problems emptying your bladder completely	yes	no
Any difficulty with erection or ejaculation	yes	no
Any testicle pain or swelling	yes	no
Date of the last prostate and rectal exam	yes	no

## IMMUNIZATIONS RECORD

Name	Date	Name	Date
Tetanus		Pneumonia	
Hepatitis		Chicken Pox	
Influenza		MMR (Measles, Mumps, Rubella)	