

# Personal & Medical Initial History Sheet ACAP Health Services

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please Print

Name \_\_\_\_\_  
Last First Maiden

Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_  
City State Zip

Client # \_\_\_\_\_

Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Home Work Cell

**Please Check all the ways we can contact you:**

- By Mail     Phone home (best time \_\_\_\_\_)
- Phone work    Other \_\_\_\_\_ (best time \_\_\_\_\_)
- Email \_\_\_\_\_
- Okay to leave message

**Race**

- White                       Black
- Native American     Asian
- Hispanic                  Other

If you are a teenager, do your parents know you're here?     Yes  No

Emergency Contact Person \_\_\_\_\_ Relation \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

**On a typical day...**

Do you smoke?  Yes  No    If yes, # per day \_\_\_\_\_  
 Do you drink coffee/tea?  Yes  No    \_\_\_\_ cups per day  
 Do you drink soda?  Yes  No    \_\_\_\_ # per day  
 How often do you drink alcohol? \_\_\_\_\_  
 How many drinks do you usually have? \_\_\_\_\_  
 Foods (check all the boxes of things you usually eat)  
      fruit                       vegetables             nuts&beans  
      milk&cheese    bread&cereal    meats&eggs  
 How often do you?    Exercise \_\_\_\_\_  
                                     Wear a seatbelt \_\_\_\_\_  
                                     Use street drugs \_\_\_\_\_  
 I am here today because \_\_\_\_\_  
 \_\_\_\_\_

**Personal Data**

Are you employed?  Yes  No  
 Place of employment \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Are you a student?  Yes  No  
 School you attend \_\_\_\_\_  
 Marital status:  
      single    married    living with partner  
 Do you have health insurance or MaineCare?  Yes  No  
 Name and ID # \_\_\_\_\_  
 Weekly gross income (before taxes) including partner/  
 Spouse living with you \$ \_\_\_\_\_  
 How many persons are supported by this income? \_\_\_\_\_  
 Have you received any services at this health center  
 before?  Yes  No

My private doctor is \_\_\_\_\_ Name of Office \_\_\_\_\_

What kinds of medical care have you received in the last year? \_\_\_\_\_  
 \_\_\_\_\_

Medications used in the last year \_\_\_\_\_

Is this going to be your first pelvic exam?  Yes  No

**Immunization History**

Rubella/MMR             Yes  No    Date \_\_\_\_/\_\_\_\_  
 Tetanus                     Yes  No    Date \_\_\_\_/\_\_\_\_  
 Tuberculosis (TB)     Yes  No    Date \_\_\_\_/\_\_\_\_  
 Hepatitis B               Yes  No    Date \_\_\_\_/\_\_\_\_  
 Do you know your blood type?  Yes  No Type \_\_\_\_\_

**Menstrual Patterns**

When was the first day of your last period?  
 \_\_\_\_\_ (approximate is okay)  
 How often do you get your periods? Every \_\_\_\_ days  
 How many days do you bleed? \_\_\_\_\_ days  
 Flow:  Light    Medium    Heavy  
 How old were you when you got your first period? \_\_\_\_\_

**General Health History**

Have you every had any of the following:

- Rubella (German Measles)       Mononucleosis (mono)  Hepatitis       Cancer       Stroke
- Diabetes       Genetic problems       Thyroid disease       Rheumatic Fever  Obesity       Asthma
- High Blood pressure       Blood transfusion       allergic to latex       Other allergies \_\_\_\_\_

Major injuries or serious illness \_\_\_\_\_

Hospitalizations or surgery \_\_\_\_\_

Did your mother ever take DES to prevent miscarriage?  Yes  No     Don't know

What medications do you take? (include over the counter and herbal/vitamin supplements) \_\_\_\_\_

**Family Health History** ( if your blood relatives are unknown to you, please skip this section)

Have your parents, grandparents, sisters, and/or brothers ever had any of the following:    Who?

- |  |  |  |
|--|--|--|
| Heart attack (at what age?)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| High blood pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Cancer <input type="checkbox"/> breast <input type="checkbox"/> uterine <input type="checkbox"/> ovarian <input type="checkbox"/> cervical | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Diabetes <input type="checkbox"/> diet controlled <input type="checkbox"/> medication controlled   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| High cholesterol   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Stroke   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Testicular or prostate cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Genetic problems   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Thyroid disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Arthritis  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Other  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**Personal Health History**    Do you have, or have you ever had any of the following:

- |   |  |  |
|---|--|--|
| Depression  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Frequent or severe headaches                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Seizures or fainting spells                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Vision problems                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Chest pain or difficulty breathing                | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Numbness or paralysis                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Heart mumur or cardiac problems                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| High cholesterol                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Blood clots or varicose veins                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Anemia/blood disease                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Breast discharge or lumps                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Stomach or intestinal problems                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Gall bladder/liver problems/jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Kidney/bladder problems/infections                | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Pain or burning during urination                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Bowel problems/bleeding/constipation/<br>diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**Menstrual & gynecological History** Do you have, or have you ever had any of the following:

- |   |  |  |
|---|--|--|
| Itching, burning, sores, odor, discharge, lower abdominal pain    | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Gonorrhea, syphilis, Chlamydia, herpes, or other sexual infection | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| PID or infection in the uterus, tubes, or ovaries                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Uterine growths, fibroids, or other problem                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Abnormal pap smear  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Pain or bleeding with intercourse                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Unusual or missed periods in the last year                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Decreased sex drive, vaginal dryness, no orgasm                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Premenstrual discomfort   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Are you currently sexually active?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**Menstrual&Gynecological History – cont’d**

Date of last pap smear \_\_\_/\_\_\_/\_\_\_ Date of last abnormal pap smear \_\_\_/\_\_\_/\_\_\_

Results: \_\_\_\_\_

Have you ever had a colposcopy?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ By whom? \_\_\_\_\_

Results: \_\_\_\_\_

Have you ever had a CRYO surgery?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ By whom? \_\_\_\_\_

Results:  LaserAblation  LEEP

Have you ever had a Cone Biopsy?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ By whom? \_\_\_\_\_

Results: \_\_\_\_\_

Have you ever had an Endometrial Biopsy?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ By whom? \_\_\_\_\_

Results: \_\_\_\_\_

Have you ever had a D&C?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ By whom? \_\_\_\_\_

Results: \_\_\_\_\_

**Contraceptive History**

Are you currently using birth control?  Yes  No What Method? \_\_\_\_\_

Other methods you have tried:

- Contraceptive film  Foam/cream/suppository  Withdrawal  Condom
- Oral Contraceptive (pill)  IUD  Depo-Provera  Vasectomy
- Diaphragm  Sponge  Tubal ligation  Patch
- Natural Family Planning  Emergency contraception  Vaginal Ring  Implanon

Problems with any of these methods? \_\_\_\_\_

What method do you want to use now? \_\_\_\_\_ Any other problems you need to discuss? \_\_\_\_\_

**Pregnancy History**

Total # of times pregnant \_\_\_\_\_ # of living children born to you \_\_\_\_\_ # of stillbirths/miscarriages/abortions \_\_\_\_\_

Date your last pregnancy ended \_\_\_\_\_ Are you breastfeeding now? \_\_\_\_\_

What types of deliveries have you had?  Vaginal  Cesarean Any complications? \_\_\_\_\_

Have you ever had an ectopic or “tubal” pregnancy?  Yes  No Have you ever had a premature delivery?  Yes  No

**Mental Health History**

Have you ever been sexually assaulted?  Yes  No

Have you ever been physically abused or hit?  Yes  No

Have you ever had mental health problems or depression?  Yes  No

Have you ever received counseling?  Yes  No

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

If my insurance is to be billed for all or part of today’s visit I authorize the release of any medical or other information needed to process the claim. I authorize payment of medical benefits to ACAP Health Services.

Please sign \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Statement of confidentiality**

This medical record is confidential, and it will not be released to any person or organization outside of ACAP Health Services without your written consent, except as outlined in our Notice of Privacy Practices (may release information without your written consent for the purposes of treatment, payment or operations)

Nurse Practitioner \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_