

**GREEN HILLS COMMUNITY ACTION AGENCY  
WOMEN'S HEALTH SERVICE**

(Please print, use black ink)

Name \_\_\_\_\_  
(First) (Last) (Maiden Name)

Address \_\_\_\_\_  
(Street/PO/RR) (City) (State/ZIP)

May we contact you at the above address? YES or NO

Please check all the ways we may contact you:

	Number	Time
<input type="checkbox"/> Call Home	_____	_____
<input type="checkbox"/> Call Work	_____	_____
<input type="checkbox"/> Mail/plain env.	_____	_____
<input type="checkbox"/> Cell Phone	_____	_____
<input type="checkbox"/> E-Mail	_____	_____

Emergency contact person: (name, relationship, phone & address)

Race: (Check all that apply)

White \_\_\_ Black \_\_\_ Asian \_\_\_ American Indian/Alaskan \_\_\_  
Native Hawaiian/other Pacific Islander \_\_\_ Unknown \_\_\_

Hispanic/Latino/Descent (circle one) YES or NO

Do you require a translator (circle one) YES or NO

Have you received services at this clinic before? YES or NO

I am here today because \_\_\_\_\_  
\_\_\_\_\_

Your private doctor(s)/clinic \_\_\_\_\_ City/State \_\_\_\_\_

Medical care in past year \_\_\_\_\_

Medications used in past year \_\_\_\_\_

Have you ever had a pelvic exam?  Yes  No  When was last pap smear \_\_\_\_\_ (date)

DO YOU HAVE A HISTORY OF:

German Measles (Rubella)  Yes  No  Vaccinated  Unknown

Mono  Cancer  Stroke  Diabetes  Genetic problems

Thyroid disease  Rheumatic fever  Obesity  Sickle Cell

Jaundice/Hepatitis  Other \_\_\_\_\_

Hospitalizations/Surgery — Type/Dates (including childbirth) \_\_\_\_\_

Major Illnesses/Injuries — Type/Dates \_\_\_\_\_

**ALLERGIES** (including metals and drugs) \_\_\_\_\_

Did your mother take DES (hormone) while pregnant with you?

Yes  No  Unknown

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

SS# \_\_\_\_\_

County of Residence \_\_\_\_\_

Date of Birth \_\_\_\_\_

Age \_\_\_\_\_

Marital Status \_\_\_\_\_

Highest Grade Completed \_\_\_\_\_

Currently a Student: YES or NO

Do you have Medicaid? YES or NO

Medicaid # \_\_\_\_\_

Do you have Medicaid that covers family planning only and no other health services: YES or NO

Do you have Private Insurance? YES or NO  
If yes, please give card to staff for copy.

Does your Private Insurance cover (check one)

Covers all or some FP services \_\_\_\_\_

Does not cover any FP services \_\_\_\_\_

Unknown FP coverage \_\_\_\_\_

Source of Income \_\_\_\_\_

Are you employed? YES or NO

Place of Employment \_\_\_\_\_

Number of persons in household \_\_\_\_\_

ON A TYPICAL DAY:

How many cigarettes do you smoke? \_\_\_\_\_

How many cups of coffee/tea/pop do you drink? \_\_\_\_\_

IN A TYPICAL WEEK HOW OFTEN DO YOU:

Exercise \_\_\_\_\_

Use alcohol \_\_\_\_\_

Use street drugs \_\_\_\_\_

HAVE YOUR BIRTH PARENTS, GRANDPARENTS, BROTHERS OR SISTERS EVER HAD ANY OF THE FOLLOWING?  
(If adopted, disregard)

	Yes	No	?	STAFF COMMENTS
1. Death from heart attack before age 50				
2. High blood pressure				
3. Breast or uterine cancer				
4. Diabetes				
5. High blood fat levels (i.e. cholesterol)				
6. Genetic problems				

**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.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION AGENCY  
Services provided on a non-discriminatory basis.

NAME \_\_\_\_\_

Do you NOW have, or have you ever had:				yes	no	?	STAFF COMMENTS		
<b>REVIEW OF SYSTEMS</b>	7. Drug Abuse						Has any partner used IV drugs? Yes/No/Unk		
	8. IV Drug Use – Abuse Not Hospitalization								
	9. Frequent or severe headaches								
	10. Seizures/fainting/neurologic disorders								
	11. Emotional problems/depression								
	12. Vision problems								
	13. Chest pain/difficult breathing								
	14. Heart problems/murmurs								
	15. High blood fat levels (i.e. cholesterol)								
	16. High blood pressure								
<b>GYNECOLOGICAL HISTORY</b>	17. Blood clots in veins/varicose veins								
	18. Anemia/blood disorders								
	19. Breast disease/lump/nipple discharge								
	20. Stomach/intestinal problems								
	21. Gall bladder or liver disease/problems								
	22. Kidney/bladder problems/infections								
	23. Pain/burning or frequent urination								
	24. Frequent vaginal infections								
	25. Unusual vaginal discharge/odor								
	26. Fever or chills								
<b>SEXUAL HISTORY</b>	27. Lower abdominal pain or pressure								
	28. Pain/bleeding with intercourse								
	29. Gonorrhea, syphilis, chlamydia, herpes, warts								
	30. PID/infection of uterus, tubes, ovaries								
	31. Uterine growth/fibroids/abnormality								
	32. Abnormal Pap smear								
	33. Are you currently sexually active?								
	34. Have you had more than one sex partner in the past year? YES/NO Number of sex partners in lifetime _____ Number of partners ___/UNK								
	35. Does your partner(s) have STD symptoms?								
	36. Know or suspected homosexuality/bisexuality in your partner: past _____ present _____								
<b>MENSTRUAL HISTORY</b>	37. Your age at time of first intercourse _____						First day of last normal period _____ How often do you get your period? Every ____ days How many days do you bleed? _____ Is your bleeding: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy Age when your period began _____ Unusual or missed periods in past years? <input type="checkbox"/> Yes <input type="checkbox"/> No Severe menstrual cramps? <input type="checkbox"/> Yes <input type="checkbox"/> No Premenstrual discomfort <input type="checkbox"/> Yes <input type="checkbox"/> No		
	38. Painful intercourse								
	39. Type of intercourse: Anal ___ Oral ___ Vaginal ___								
<b>PREGNANCY HISTORY</b>							<b>CONTRACEPTIVE HISTORY</b>		
Age at First Pregnancy _____ Number of Living Children _____									
Could you be pregnant now? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe									
Date Preg. Ended	Complication with Preg./Del.	Vaginal	Abortion	Caesareans	Live Birth	Mis-carriage			No. of Weeks
RH NEGATIVE <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> Unknown Toxemia <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> If Pregnancy was in last 12 months: <input type="checkbox"/> Intended <input type="checkbox"/> Unintended not using birth control <input type="checkbox"/> Unintended using birth control Other _____ Any genetic abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No									Are you currently using birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which method _____ How long have you used this method? _____ Problems, if any _____ Other methods of birth control used: <input type="checkbox"/> Oral (pill) <input type="checkbox"/> Condom <input type="checkbox"/> IUD <input type="checkbox"/> Withdrawal <input type="checkbox"/> Diaphragm/Nuva Ring <input type="checkbox"/> Patch <input type="checkbox"/> Foam/cream/suppository/film <input type="checkbox"/> Self Sterile <input type="checkbox"/> Rhythm/NFP <input type="checkbox"/> Partner Sterile <input type="checkbox"/> Implant <input type="checkbox"/> Depo Provera Problems with any of these methods: <input type="checkbox"/> Yes <input type="checkbox"/> No What method do you want now? _____ Do you plan to have children in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided