WEST VIRGINIA DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
OFFICE OF MATERNAL, CHILD, AND FAMILY HEALTH
DIVISION OF WOMEN'S AND FAMILY HEALTH
FAMILY PLANNING PROGRAM

West Virginia Department of HEALTH

MEDICAL HISTORY

DATE: _____ **SOCIAL SECURITY NUMBER:** _____

NAME: _____ **DATE OF BIRTH:** ____/____/____ **AGE**: _____

CURRENT MEDICATIONS: (prescriptions and over-the-counter) _____

ALLERGIES: (list any medicines, foods, latex, etc. that you are allergic to and the reaction you have) _____
_____

HISTORY (√ all that apply)	**SELF**	**FAMILY**
Allergies		
Hospitalizations		
Surgery		
Headaches		
Epilepsy/Seizures		
Depression/Anxiety		
Thyroid disease		
Breast cancer or other breast problems		
Heart diseases or abnormal heart conditions		
High blood pressure		
Blood clot to leg (DVT) or Lung Clot (PE)		
Varicose veins		
Cancer		
Lung problems		
Liver disease/Hepatitis		
Kidney/Bladder problems		
Diabetes		
Hormone problems		
Ovarian or Uterine Cancer		
Endometriosis		
Fibroids/Ovarian Cysts		
Vaginal infections		
Sexually transmitted diseases/HIV/Hepatitis B Virus		
Alcohol use		
Drug use		
Tobacco or Vape use (If yes, please circle which)		
Breast implants		
In the past 48 hours, have you douched, used tampons, spermicidal or vaginal creams or had intercourse?		
Immunizations up to date?		
Blood transfusion or exposure to blood products?		

ANYONE WHO HAS A CERVIX OR INTERNAL GENITALS:

PREGNANCY HISTORY:
pregnancies: _____ Age first pregnancy: _____
live births: _____ # living children: _____
miscarriages: _____ # abortions: _____
Complications: _____
_____

CONTRACEPTIVE HISTORY:
Current birth control method: _____
Any problems: _____
Do you want to continue your present birth control method? _____

MENSTRUAL/SEXUAL HISTORY:
First day of last menstrual period? _____
Are your periods regular? _____
Are your periods: Light __ Medium __ Heavy __
Do you miss periods? _____
Severe cramping? _____
Age when periods started? _____
Pain/bleeding with intercourse? _____
Number of sexual partners (lifetime)? _____
Are you currently having sex with more than one person? _____

PAP HISTORY:
Ever had an abnormal Pap smear? _____ Date: _____
Treatment, if any: _____
Last Pap smear (date): _____

ANYONE WHO HAS EXTERNAL GENITALS:
Are you currently having sex with more than one person? _____
Do you use condoms? _____
Urological problems? _____

ALL CLIENTS
SEXUAL HISTORY:
Do you or your partner use injectable drugs? _____
Do you or your partner have sex with more than one person? _____
Do you or your partner have a history of STD/HIV/Hep B Virus? ____
If you are ≤15, what is/are the age(s) of your sexual partner(s)? _____

PERSONAL HISTORY: (all clients)
Have you ever been hit, slapped, kicked, shaken or hurt by anyone? ____
Is there anyone who makes you feel unsafe now? _____
Has anyone pressured you to perform a sexual act? _____
Have you ever been forced to have sex? _____

CLIENT SIGNATURE **DATE**

CLINICAL STAFF SIGNATURE/TITLE **DATE**

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PHYSICAL EXAM INFORMATION

NAME:_____ **VISIT TYPE:**_____

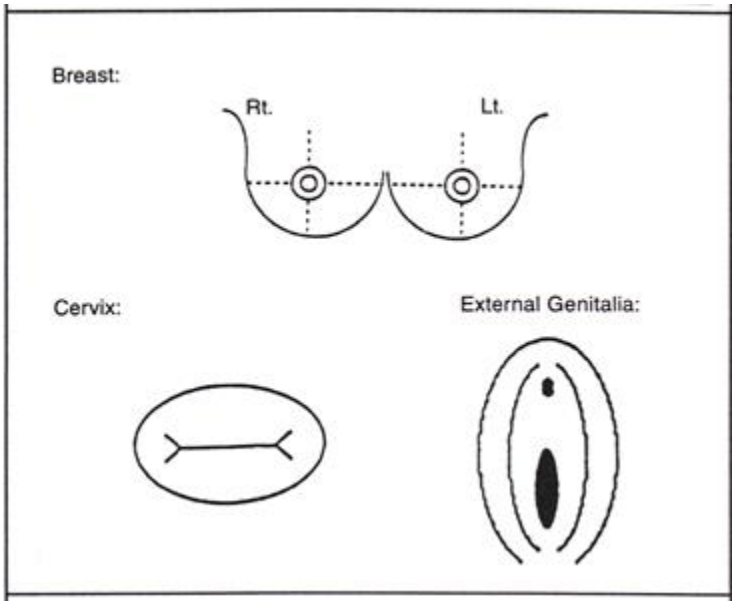
HEIGHT:_____ **WEIGHT:**_____ **B/P:**_____ **BMI:**_____ **LMP:**_____

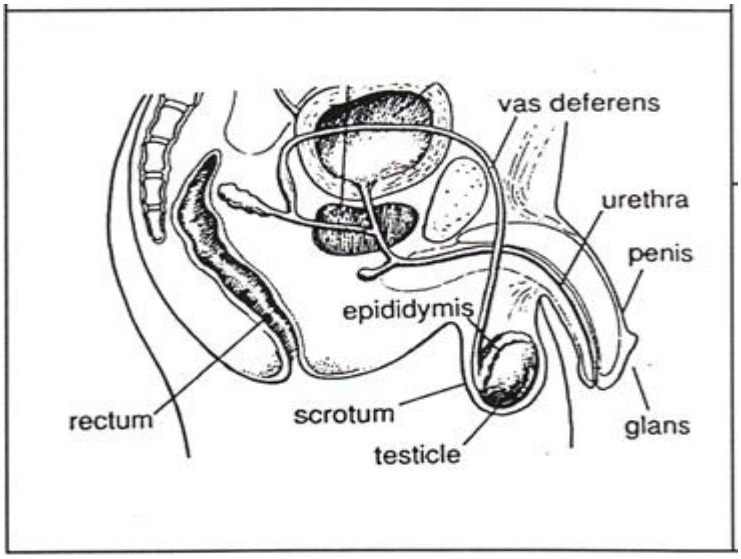
HEENT _____
Skin _____
Thyroid _____
Heart _____
Lungs _____
Abdomen _____
Extremities _____

FEMALE
External Genitalia _____
Vagina _____
Cervix _____
Uterus _____
Adnexa _____
Rectal _____
Breast _____

LAB TESTS:	Completed	Results
RPR	_____	_____
GC Culture	_____	_____
Pap Smear	_____	_____
Hgb/Hct	_____	_____
Urine	_____	_____
Pregnancy Test	_____	_____
Rubella Titer	_____	_____
Chlamydia	_____	_____
Wet Prep	_____	_____
Hemoccult	_____	_____
Other	_____	_____

MALE
External Genitalia _____
Testicles _____
Rectal _____
Breast _____





ABNORMAL TEST RESULTS REPORTED TO CLIENT:
_____ **Client called** **Date** _____
_____ **Client called** **Date** _____
_____ **Letter sent** **Date** _____
_____ **Other contact** **Date** _____

METHOD/MEDICATION DISPENSED:
_____
_____
_____
_____

ASSESSMENT/PLAN:
_____
_____
_____
_____

Signature: Clinical Service Provider and Title **Date**