Chart #_____

Date of Birth _____

Age _____

LEE COUNTY HEALTH DEPARTMENT

Dixon, Illinois 61021

% Pay _____

Date _____

ANNUAL HISTORY UPDATE

PLEASE PRINT

Name _____ Phone: Day (_____)_____
Last First Maiden

Address _____ evening (_____)_____
Street City State Zip

work (_____)_____

cell (_____)_____

Please check **all** the ways we may contact you:

☐ Call Home ☐ Call Work ☐ Write Home ☐ Write Home (plain envelope) ☐ Other _____

May we say it's the Health Department calling? ☐ Yes ☐ No Social Security # _____

The services you receive here are covered by: ☐ Private Insurance ☐ Medicaid/Kidcare Programs

CONTACT PERSON: _____ Relationship _____

Address _____ Phone: (_____)_____

Race: ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Hispanic ☐ Other

Primary source of income: ☐ Self ☐ Spouse/Partner ☐ Parents Student: ☐ Yes ☐ No

What is the family yearly gross income (before deductions)? Include yours PLUS spouse. $ _____

How many persons are supported by this income? Include yourself, spouse and children _____

I am here today because: _____

Your private doctor: _____

Medical care in past year: _____

Medications used in past year: _____

Last Pap Smear _____/_____ Results _____ Blood transfusions? _____ Years _____

GENERAL HEALTH

SINCE YOUR LAST VISIT HAVE YOU HAD:

☐ Hepatitis ☐ Stroke ☐ Diabetes ☐ Thyroid disease

☐ Rheumatic fever ☐ Mono ☐ Obesity ☐ Other (Specify) _____

_____ (Specify)

ALLERGIES (including metals) _____

_____

Other Medical Problems _____

_____

Questions/concerns I would like to discuss _____

_____

Did your mother take DES (hormone to prevent miscarriage)?

☐ Yes ☐ No ☐ Unknown

ON A TYPICAL DAY:

How many cigarettes do you smoke? ____

How many servings of the following do you eat? fruits ____ nuts/beans ____

breads/cereals ____ eggs/meats ____

milk/dairy products ____ vegetables ____

coffee/tea/cola ____

IN A TYPICAL WEEK HOW OFTEN DO YOU:

Exercise _____

Use alcohol _____

Use street drugs _____

FAMILY HISTORY

FAMILY HISTORY (unless adopted) - Please circle adopted if applicable

Have your parents, brothers or sisters ever had:	YES	NO	?	STAFF COMMENTS
1. 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				
7. Other				

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.

(continued on reverse side)

REVIEW OF SYSTEMS / MENSTRUAL/GYNECOLOGICAL HISTORY

Since your last visit: Do you now have, or have you ever had:	YES	NO	?	STAFF COMMENTS
8. Frequent or severe headaches				
9. Vision problems/corrective lenses				
10. Emotional problems/depression				
11. Frequent nausea/vomiting				
12. Chest pain/difficulty breathing/heart problems				
13. Blood clots in veins				
14. Arm or leg pain/numbness/tingling				
15. High blood pressure				
16. Severe abdominal pain				
17. Breast disease/lump/nipple discharge				
18. Kidney/bladder problems/infections				
19. Pain or burning with urination				
20. Frequent vaginal infections				
21. Unusual vaginal discharge/odor				
22. Vaginal itching/burning/sores				
23. STD/gonorrhea/syphilis/other				
24. PID/infection of uterus, tubes, ovaries				
25. Pain/bleeding with intercourse				
26. Unusual or missed periods in past years				
27. Bleeding or spotting between periods				
28. Severe menstrual cramps				
29. Premenstrual discomforts				

30. First day of last normal period ____/____/____

31. How many days do you bleed? _____ days

32. Ave. number of pads/tampons used per day _____

CONTRACEPTIVE HISTORY

Are you currently using a method of birth control?

☐ Yes ☐ No

If yes, which method? _____

How long have you used this method? _____

Problems, if any _____

_____

Other methods of birth control used in past:

☐ Oral (pill) ☐ Condom ☐ Depo

☐ IUD ☐ Withdrawal ☐ Patch

☐ Diaphragm ☐ Sponge

☐ Foam/cream/suppository ☐ Self sterile

☐ Rhythm/NFP ☐ Partner sterile

Problems with any of these methods: _____

_____

What method do you want to use now? _____

SEXUAL HISTORY

Are you currently sexually active? ☐ Yes ☐ No

Do you think you may be pregnant now? ☐ Yes ☐ No

Have you had sex without using birth control since your last period ☐ Yes ☐ No

Having more than one sex partner increases the chance of sexual diseases:
Have you had more than one sex partner in the past six months? ☐ Yes ☐ No

PREGNANCY HISTORY

Have you been pregnant in the last year? ☐ Yes ☐ No

Total number of times pregnant .....____

List month and year each pregnancy ended _____

_____

Number of living children .....____

Number of stillbirths .....____

Number of miscarriages .....____

Number of induced abortions .....____

Your age at time of first pregnancy .....____

Types of deliveries ☐ Vaginal ☐ Caesarean

Complications with any pregnancies i.e. toxemia, genetic problems, diabetes? ☐ Yes ☐ No If yes, explain _____

_____

Have you ever had an ectopic (tubal) pregnancy? ☐ Yes ☐ No

Have you ever had any premature deliveries? ☐ Yes ☐ No

Partner History Reviewed: ☐ Yes ☐ No

EMERGENCY CONTACT (Parent/Guardian): Name _____ Relationship _____

Address _____ Phone _____

Teens under 18 years: Parental involvement encouraged? ☐ Yes ☐No Parents know? ☐Yes ☐ No Abstinence Education? ☐ Yes ☐ No

Counseled to resist coercion to engage in sexual activity? ☐ Yes ☐ No

REVIEWED BY: _____ Date _____/_____/_____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of Client _____ Date _____/_____/_____