Chart #_____

Date of Birth _____

Age _____

LEE COUNTY HEALTH DEPARTMENT

Dixon, Illinois 61021

% Pay _____

Date _____

INITIAL HISTORY

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 Program

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 _____

Have you received Family Planning at this clinic before? ☐ Yes ☐ No

I am here today because: _____

Your private doctor: _____

Medical care in past year: _____

Medications used in past year: _____

Last Pap Smear _____/_____ Results _____ Is this your first pelvic exam? ☐ Yes ☐ No
month year

GENERAL HEALTH

DO YOU HAVE A HISTORY OF:

German Measles (Rubella) ☐ Yes ☐ No ☐ Vaccinated ☐ Unknown

☐ Hepatitis ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Genetic problems

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

Hospitalizations/Surgery _____

_____

Major Illnesses/Injuries _____

Allergies (including metals) _____

_____

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

☐ Yes ☐ No ☐ Unknown Blood transfusions? _____ Year _____

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)

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

Do you now have, or have you ever had:	YES	NO	?	STAFF COMMENTS
8. Frequent or severe headaches				
9. Seizures/fainting spells				
10. Emotional problems/depression				
11. Vision problems				
12. Chest pain/difficulty breathing				
13. Heart problems/murmurs				
14. High blood fat levels (i.e. cholesterol)				
15. High blood pressure				
16. Blood clots in veins/varicose veins				
17. Anemia				
18. Breast disease/lump/nipple discharge				
19. Stomach/intestinal problems				
20. Gall bladder or liver disease/problems				
21. Kidney/bladder problems/infections				
22. Pain or burning with urination				

MENSTRUAL/GYNECOLOGICAL HISTORY

23. Frequent vaginal infections				
24. Unusual vaginal discharge/odor				
25. Vaginal itching/burning/sores				
26. STD/gonorrhea/syphilis/other				
27. PID/infection of uterus, tubes, ovaries				
28. Uterine growths/fibroids/abnormality				
29. Abnormal Pap smear				
30. Pain/bleeding with intercourse				
31. Unusual or missed periods in past years				
32. Severe menstrual cramps				
33. Premenstrual discomforts				

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

35. How often do you get your period? Every _____ days

36. How many days do you bleed? _____ days

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

38. Age periods began _____

39. Your age at time of first intercourse _____

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
☐ IUD	☐ Withdrawal
☐ 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

Partner risks reviewed? ☐ Yes ☐ No

PREGNANCY HISTORY

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

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

Address _____ Phone _____

Teens under 18 years: Parental involvement encouraged? ☐ Yes ☐ No Parents know? ☐ Yes ☐ No Reviewed ABC_____ ☐

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 _____/_____/_____