Lee County Health Department Health Intake Form

Legal Name: _____

Chosen name (if different from birth name): _____

Sex at birth (check one): ☐ Male or ☐ Female

Current gender (check one): ☐ Male ☐ Female ☐ Intersex ☐ Transgender M to F ☐ Transgender F to M

Sexual orientation (check one): ☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Other

Relationship status (check one): ☐ Single ☐ Married ☐ Partnered ☐ Living Together ☐ Divorced

Pronouns: _____

DOB: _____

Ethnicity (check one): ☐ Hispanic or ☐ Non-Hispanic **Race:**

Address: _____

Preferred contact phone number: _____

Is it okay to: (check all that apply): ☐ call ☐ text ☐ leave voicemail

Emergency contact: **Name:** _____ **phone number:** _____

Household size: _____ **Yearly household income**: _____

Reason for visit in your own words: _____

_____

Primary care provider: _____

Date of last pap smear: _____

Are you currently using a method of contraception? If so, list here: _____

Methods of birth control used in the past? _____

Have you had your HPV Vaccine? ☐ Yes ☐ No ☐ Unsure

Do you or have you ever smoked cigarettes? (vaping/marijuana not included):

☐ Current, daily ☐ Current, occasionally ☐ Never ☐ Former

How often do you use alcohol? _____

How often do you exercise? _____

Hospitalizations or surgery in the past? _____

_____

Any major Illness or ongoing medical problems? _____

_____

_____

Do you take any medications? If so list them here : _____

_____

Do you have any medication allergies? _____

_____

Family History: (check any that apply & list which family member was affected)

- ☐ **Heart attack :**_____
- ☐ **High blood pressure:**_____
- ☐ **Genetic problems:** _____
- ☐ **Breast/uterine/ovarian cancer:**_____
- ☐ **High cholesterol:**_____
- ☐ **Diabetes:** _____
- ☐ **Other:** _____

Review of systems

Do you have currently or a history of (write yes or no):

1. **Frequent or severe headaches**_____
2. **Seizures or fainting episodes** _____
3. **Emotional concerns/anxiety/depression** _____
4. **Vision problems** _____
5. **Chest pain or difficulty breathing** _____
6. **Heart problems or history of heart murmur** _____
7. **History of high blood pressure or high cholesterol** _____
8. **Anemia** _____
9. **Blood clots or varicose veins** _____
10. **Breast concerns** _____
11. **Stomach or intestine problems** _____
12. **Liver or gallbladder disease** _____
13. **Urinary problems/kidney problems/UTIs** _____
14. **Frequent vaginal infections** _____
15. **STI/STDs or PID (pelvic inflammatory disease)** _____
16. **Vaginal discharge, itching or odor** _____
17. **Abnormal pap smear** _____
18. **Pain or bleeding with sex** _____
19. **Severe menstrual cramps** _____
20. **Irregular menstrual cycles** _____

Are you currently sexually active? _____

Do you think you could be pregnant? _____

Number of sexual partners in the past 6 months? _____

Total number of pregnancies? _____ **Total number of living children:** _____