CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Reproductive Health Branch

Place Patient Label Here

BIOLOGICAL FEMALE REPRODUCTIVE HEALTH HISTORY

Date: _____

A. GENERAL INFORMATION

1. May we contact you by mail? ☐ Yes ☐ No By phone? ☐ Yes ☐ No Your phone number is _____
2. Do you have a primary care provider? ☐ Yes ☐ No If yes, who? _____
   If No a referral to a primary care provider is offered ☐ Yes ☐ No
3. Hearing, Visual, Language and/or Physical Accommodation needs/Primary Language(s) _____
4. Highest grade completed in school _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you take a multivitamin and/or a folic acid? ☐ Yes ☐ No Do you currently take any medications (prescription or over the counter), diet or herbal supplements? ☐ Yes ☐ No If yes, what? _____
3. Self and Family Medical History: Put an **X** under **SELF** and/or **X** under **FAMILY** (parent, grandparent, brother, sister or your child)

SELF	FAMILY		SELF	FAMILY	
☐	☐	1. Heart disease/vascular problems (blood clots)	☐	☐	8. Liver Disease
☐	☐	2. Sickle Cell Disease or Trait/Blood Disorder	☐	☐	9. Migraine Headache (with aura)
☐	☐	3. Diabetes	☐	☐	10. Cancer
☐	☐	4. High Blood Pressure /High cholesterol	☐	☐	11. Mental Illness/Emotional Disorders
☐	☐	5. Autoimmune Disease	☐	☐	12. Chronic Kidney Disease
☐	☐	6. Lung Disease	☐	☐	13. Other
☐	☐	7. Infertility			

If yes to any of the above, please explain:

C. GYNECOLOGICAL HISTORY

1. Menstrual history: At what age did you have your first period?_____How often do you have your period? _____
   How many days does your bleeding last? _____Do you have any concerns about your periods? _____
2. Any history of gynecologic conditions such as endometriosis, fibroids, ovarian cysts, chronic pelvic pain, polycystic ovarian syndrome, infertility, etc.? _____
3. Breast problems such as cysts, tumors, discharge, biopsies, or surgeries? _____
4. Date of last Mammogram_____
5. Date of last Pap test _____History of any abnormal Pap tests? ☐ Yes ☐ No If yes, in what year, what results, and what was done? _____
6. **Past birth control methods used:** ☐ OCP (type)_____ ☐ Depo ☐ Condoms ☐ BTL ☐ Patch ☐ Ring ☐ Implant ☐ IUD ☐ FABM ☐ Other ☐ None

Concerns or problems with past methods? _____

D. Obstetrical History

1. Gravida _____ # Carried to term _____ # Preterm _____ #Abortion/Miscarriage <20 weeks _____ #Living _____

E. SOCIAL/ENVIRONMENTAL HISTORY

1. Do you currently use tobacco, including cigarettes, smokeless tobacco, electronic devices, or other products?
   ☐ Yes ☐ No If yes, what type?_____How long? _____
2. Drink alcohol? ☐ Yes ☐ No If yes, how much?_____How long? _____
3. Use recreational drugs? ☐ Yes ☐ No If yes, what type?_____How often? _____

4. Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or recreational drugs?
   ☐ Yes ☐ No If yes, what do they use?_____How often? _____

F. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = up-to-date; REF = referred, and NA = not applicable)

Td/Tdap ☐ UTD ☐ REF ☐ NA	MMR ☐ UTD ☐ REF ☐ NA	Varicella ☐ UTD ☐ REF ☐ NA	HPV ☐ UTD ☐ REF ☐ NA	Hepatitis A ☐ UTD ☐ REF ☐ NA
Hepatitis B ☐ UTD ☐ REF ☐ NA	Meningococcal ☐ UTD ☐ REF ☐ NA	Pneumonia ☐ UTD ☐ REF ☐ NA	Influenza ☐ UTD ☐ REF ☐ NA	

Source of Information: ☐ NCIR ☐ Patient ☐ Other Written Documentation

Interviewer's Signature: _____Date: _____

Signature of Interpreter (if used): _____Date: _____