Rusk County Health & Human Services 311 E. Miner Ave. Suite C220 Ladysmith, WI 54848 (ph) 715-532-2299 (fax) 715-532-2217	Legal Name:		
	Date of Birth:	Sex at Birth: ☐Male ☐ Female	Date of Service:

HEALTH HISTORY FOR:	Preferred Name:	Preferred Pronouns:

Reason for Visit:			
	☐Contraceptive Services	☐Pregnancy Testing & Counseling	☐Basic Infertility Services
	☐STI Services	☐Preconception Health Services	☐Related Preventive Health Services

SUBJECTIVE:

Have you traveled outside the U.S. within the last 30 days? ☐ Yes ☐ No If yes, where:_____

Please list allergies: ☐ No known allergies

Medications, vitamins, over the counter drugs, and/or herbs you take:_____

MENSTRUAL HISTORY ☐ N/A

Day last period began:_____ Age when periods started:_____ Was it Normal? ☐ Yes ☐ No

Do you have bad cramps? ☐ Yes ☐ No Do you bleed heavy? ☐ Yes ☐ No

Have you had sex since your period? ☐ Yes ☐ No If yes, when:_____

SEXUAL HISTORY ☐ N/A

Have you ever had sex? ☐ Yes ☐ No

Who do you have sex with? *Check all that apply.*

☐ Men ☐ Women ☐ Both ☐ Non-binary ☐ Other identities: _____

What type of sex do you have?

☐ Vaginal (penis in vagina) ☐ Oral sex (genitals in mouth) ☐ Anal sex (penis in rectum/anus)

Have you or your partner had more than one sexual partner in your lifetime? ☐ Yes ☐ No ☐ I don't know

Have you or your partner(s) used IV drugs? ☐ Yes ☐ No ☐ I don't know

In the last 90 days…

Have you had a new partner or more than one partner? ☐ Yes ☐ No ☐ I don't know

Has your partner(s) had a new sex partner or more than one partner? ☐ Yes ☐ No ☐ I don't know

Have you had symptoms or a diagnosis of a STI? ☐ Yes ☐ No ☐ I don't know

Has your partner had symptoms or a diagnosis of a STI? ☐ Yes ☐ No ☐ I don't know

Have you ever had: ☐ Chlamydia ☐ Gonorrhea ☐ HIV ☐ HPV/warts ☐ Herpes ☐ Syphilis

REPRODUCTIVE LIFE PLAN

Would you like to have a child in the next year? ☐ Yes ☐ No

If yes, do you desire to have a child now? ☐ Yes ☐ No

What can I do today to help you achieve your plan? _____

CONTRACEPTIVE HISTORY

Do you ALWAYS use condoms? ☐ Yes ☐ No

Are you using birth control now? ☐ Yes ☐ No If yes, what kind: _____

Do you want birth control today? ☐ Yes ☐ No If yes, what kind: _____

What kind of birth control have you used in the past? Any problems with those methods? _____

GYNECOLOGIC HISTORY ☐ N/A

Date of your last pap smear:_____ What Clinic?_____

Have you had:☐ Colposcopy ☐ LEEP ☐ Other Treatment:_____

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OB HISTORY ☐ N/A *As needed, list additional pregnancies on page 5.

Date of delivery	Type of delivery	Place of delivery	Complications	Assigned Gender

Have you had a history of premature labor? ☐ Yes ☐ No G: _____ P: _____

Have you had an ectopic pregnancy? ☐ Yes ☐ No P: _____ Ab: _____

Have you ever had any abortions (induced or spontaneous)? ☐ Yes ☐ No T: _____ L: _____

PAST MEDICAL HISTORY

Have you ever been in the hospital? ☐ Yes ☐ No If yes, why? _____

Do you have a primary care provider? ☐ Yes ☐ No If yes, name: _____

Do you now have or have you ever had?

Yes	*No*	*Condition*	*Yes*	*No*	*Condition*	*Yes*	*No*	*Condition*
☐	☐	Abnormal pap test	☐	☐	Pelvic infection/PID	☐	☐	Heart disease/hypertension
☐	☐	Anemia	☐	☐	Gall bladder disease	☐	☐	Thrombophlebitis/blood clot(s)
☐	☐	Asthma	☐	☐	Genetic condition	☐	☐	Uterine growth/fibroid
☐	☐	Breast surgery	☐	☐	Thyroid problems	☐	☐	Sickle cell anemia
☐	☐	Cancer	☐	☐	Stroke	☐	☐	Blood disorders
☐	☐	Diabetes	☐	☐	Liver disease	☐	☐	Kidney/bladder Problem
☐	☐	Bariatric surgery	☐	☐	Severe depression	☐	☐	Seizure disorder/epilepsy
☐	☐	HIV/AIDS	☐	☐	DES exposure	☐	☐	Endometriosis/ovarian cysts
☐	☐	Stomach problems	☐	☐	Mono or Hepatitis	☐	☐	Migraine headaches with aura
☐	☐	Tuberculosis	☐	☐	High cholesterol	☐	☐	Mitral Value Prolapse (MVP)

FAMILY HISTORY

If you do not know your family's medical history go to next section. Does your mother, father, brother, or sister have any of the following:

Yes	*No*	*Condition*	*Yes*	*No*	*Condition*	*Yes*	*No*	*Condition*
☐	☐	Stroke	☐	☐	Diabetes	☐	☐	Breast cancer
☐	☐	Heart attack	☐	☐	High cholesterol	☐	☐	Ovarian cancer
☐	☐	Blood clot	☐	☐	High blood pressure	☐	☐	Prostate cancer
☐	☐	Osteoporosis	☐	☐	Hereditary	☐	☐	Colon cancer

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SOCIAL HISTORY

In the past 12 months, how often have you:	Daily or Almost Daily	Weekly	Monthly	Less Than Monthly	Never
Used any tobacco product?	☐	☐	☐	☐	☐
Had 5 [men] or 4 [women] or more drinks on occasion?	☐	☐	☐	☐	☐
Used any street drugs such as marijuana, cocaine, heroin, methamphetamine, hallucinogens, ecstasy?	☐	☐	☐	☐	☐
Used any prescription medications just for the feeling, more than prescribed, or that were not prescribed for you?	☐	☐	☐	☐	☐

Over the last two weeks, how often have you been bothered by any of the following problems?:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

REPRODUCTIVE/SEXUAL COERCION

Has anyone sabotaged your birth control? ☐ Yes ☐ No

Has anyone pressured you to become pregnant when you did not wish to? ☐ Yes ☐ No

Has anyone threatened or forced you to terminate a pregnancy? ☐ Yes ☐ No

Has anyone pressured or coerced you to have sexual contact when you did not wish to? ☐ Yes ☐ No

INTIMATE PARTNER VIOLENCE Does your partner…

Physically hurt you? ☐ Yes ☐ No

Threaten you with harm? ☐ Yes ☐ No

Scream or curse at you fairly often? ☐ Yes ☐ No

Insult you or talk down to you fairly often? ☐ Yes ☐ No

IMMUNIZATIONS

☐ Hepatitis A Series Complete ☐ Hepatitis B Series Complete ☐ HPV Series Complete

☐ Vaccines Needed: _____

REVIEW OF SYSTEMS

What parts are we caring for today: ☐ Penis | ☐ Testicles | ☐ Vagina | ☐ Uterus | ☐ Ovaries | ☐ Other

General
- ☐ Reactions to drugs/foods
- ☐ Weight gain or loss

Skin
- ☐ Acne
- ☐ Rash

Genitourinary
- ☐ Blood in urine
- ☐ Pain/frequent urination
- ☐ Bumps/ sores/rash
- ☐ Discharge/irritation/odor
- ☐ Pain with intercourse

Eye, Ears, Nose, Throat
- ☐ Hearing problems
- ☐ Frequent nose bleeds
- ☐ Frequent sore throat
- ☐ Thyroid problems
- ☐ Blurred/Double vision

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Varicose Veins

Musculoskeletal
- ☐ Muscle pain
- ☐ Back pain
- ☐ Bone pain

Neuro/Psych
- ☐ Convulsions/seizures
- ☐ Memory/speech difficulty
- ☐ Sadness/anxiety
- ☐ Numbness/tingling
- ☐ Headaches

Gastrointestinal
- ☐ Abdominal pain
- ☐ Changes in bowel habits
- ☐ Changes in appetite
- ☐ Constipation/diarrhea
- ☐ Rectal pain or bleeding

Chest
- ☐ Breast lump
- ☐ Breast pain
- ☐ Nipple discharge

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Breathing problems

DIET & EXERCISE

How many meals do you eat a day?_____ How much coffee, tea and soda per day? _____

What do you do for physical activity? _____ How many hours of sleep do you get? _____

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OBJECTIVE:

BP:_____mmHg HT:_____inches WT:_____pounds BMI:_____kg/m^2

LABS ☐ Reference applicable laboratory reports

IN HOUSE LABS				OUTSIDE LABS ORDERED			
HCG		CT		Cervical	☐ CT ☐ GC	☐ Syphilis	
Blood Glucose		GC		Pharyngeal	☐ CT ☐ GC	☐ HIV	
UA: glucose		TRICH		Rectal	☐ CT ☐ GC	☐ HCV	
UA: leuko		HIV		Urethra	☐ CT ☐ GC	☐ LB: thin prep	
UA: nitrite		HCV		Urine	☐ CT ☐ GC	☐ Other:	
UA: protein		SYPHILIS		Vaginal	☐ CT ☐ GC		

ASSESSMENT/PLAN:

Assessment	Plan
No contraindications to Emergency Contraception use	Levonogestrel 1.5mg 1 tab PO PRN x 1 year RX: _____
No Contraindications to: _____	○ Start_____ x 12 cycles with 3 month extension ☐ Today ☐ Tomorrow ☐ With next menses ☐ Back up x 7 days ☐ Continue w/ current method RX: _____
Dual Protection (education)	☐ Male Condoms PRN x 1 year RX: _____
STI Testing	☐ Urine Sample ☐ Visby (in house)

HEALTH EDUCATION & COUNSELING:

☐ Alcohol and other drug use	☐ Folic Acid	☐ Sexual behavioral risk reduction
☐ Blood Pressure	☐ Immunizations	☐ Tobacco use
☐ BMI	☐ IPV	☐ Sexual Coercion/Family Involvement
☐ Depression	☐ RLP	☐ FDA-approved contraceptive methods
☐ Other:	☐ 1200mg Calcium	☐ Folic Acid (400-800mcg/day)

Total Time: _____ Provider Signature: _____ Date _____

NON-MEDICAL EDUCATION & COUNSELING:

☐ FPOS Covered Services	☐ General Consent	☐ Clinic hours & contact information
☐ TE/EE/CE Process	☐ Release of Information	☐ Other:

Staff notes:_____

_____

Total Time: _____ Staff Signature: _____ Date _____