1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYY Y)	Month / Day / Year	
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White		
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported		
6. Gender ☐ Female ☐ Male		
7. County of Residence		
8. Home Address:	9. Marital Status:	

CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

FEMALE REPRODUCTIVE HEALTH HISTORY

Date: ______________________________

A. GENERAL INFORMATION (Please complete the following)

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. Special Needs/Primary Language ______________________
4. Highest grade completed in school ______________________

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: ______________________
2. Medications: Do you take a multivitamin with folic acid? ☐ Yes ☐ No Do you 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 (heart attack, blood clots, stroke)	☐	☐	6. Liver Disease
☐	☐	2. Sickle Cell Disease or Trait/Blood Disorder	☐	☐	7. Migraine Headache (with aura)
☐	☐	3. Diabetes/Gestational Diabetes (if postpartum and had GDM, then repeat screening)	☐	☐	8. Cancer
☐	☐	4. High Blood Pressure /High cholesterol	☐	☐	9. Mental Illness/Emotional Disorders
☐	☐	5. Lung Disease	☐	☐	10. Other
If yes to any of the above, please explain:					

C. GYNECOLOGICAL HISTORY

1. Menstrual history: At what age did you start your period?__________How often do you have your period? ______________________
   How many days does your bleeding last? _______Any problems? ______________________
2. Any history of female conditions such as endometriosis, ovarian cysts, chronic pelvic pain, etc.? ______________________
3. Breast problems such as breast lumps, biopsies, surgeries? ______________________
4. Date of last Mammogram______________________
5. Date of last Pap test ____________________History of any abnormal Pap tests? ☐ Yes ☐ No If yes, what was done and in what year?
   ____
6. **Past birth control methods used:** ☐ OCP (type)__________ ☐ Depo ☐ Condoms ☐ BTL ☐ Patch
   ☐ Ring ☐ Implant ☐ IUD ☐ FABM ☐ Other ☐ None
   Problems with past methods______________________

D. Obstetrical History

1. Gravida ________ # Carried to term ________ # Preterm ________ #Abortion/Miscarriage ________ #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 often? ________________

2. Drink alcohol? ☐ Yes ☐ No If yes, how much?________________ How often? ________________

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: ______________