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CONFIDENTIAL

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

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 (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 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	MMR	Varicella	HPV	Hepatitis A
☐ UTD ☐ REF ☐ NA	☐ UTD ☐ REF ☐ NA	☐ UTD ☐ REF ☐ NA	☐ UTD ☐ REF ☐ NA	☐ UTD ☐ REF ☐ NA
Hepatitis B	Meningococcal	Pneumonia	Influenza	
☐ UTD ☐ REF ☐ NA	☐ UTD ☐ REF ☐ NA	☐ UTD ☐ REF ☐ NA	☐ UTD ☐ REF ☐ NA	

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

Interviewer's Signature: ____Date: _________________

Signature of Interpreter (if used): ____Date: _________________