Office Use Only

Client ID Confirmed No ☐ Yes ☐

Use CARE ☐ YES ☐ NO

REPRODUCTIVE HEALTH HISTORY

Legal Name: _____ _____ Preferred Name: _____
Last First

Date of Birth: _____
(DD/MMM/YYYY)

Address: _____ _____ _____ _____
(PO Box/Street #/Street Name) (City/Town) (Province) (Postal Code)

Home Phone: _____ Cell: _____ Permission to text you? ☐ Yes ☐ No

Permission to email? No ☐ Yes ☐ Email address: _____

MHSC#: _____ PHIN #: _____

Primary Care Provider: _____ Phone: _____

Personal History
Check all that apply:

☐ Allergies _____
☐ Current medications_____
☐ Heart or blood pressure problems
☐ Bleeding or clotting problems
☐ Diabetes
☐ Headaches or migraines
☐ Vaginal or bladder infection
☐ Liver problems or hepatitis
☐ Breast lumps
☐ Ovarian cysts
☐ Pelvic inflammatory disease (PID)
☐ Skin problems or acne
☐ Muscle or bone problems
☐ Depression or anxiety
☐ Other_____

Family History
Check all that apply:

Does anyone in your family have the following:

☐ Cancer of the breast, uterus or ovary
☐ Heart disease (heart attack)
☐ High blood pressure
☐ Thrombosis / CVA (strokes) / blood clotting disorders
☐ Diabetes
☐ Other_____

_____

_____

Reproductive History:

How old were you when you started your period? ____ Years old. Are your periods painful? No ☐ Yes ☐

When did you start your last period? _____ How many days does your period usually last? _____

How often do you get your period (from start of one to start of next period)?
☐ Every 28 days ☐ More than every 28 days ☐ Less than every 28 days ☐ Other_____

Have you ever had a pregnancy test done before? No ☐ Yes ☐ If yes, when? _____

Have you ever been pregnant before? No ☐ Yes ☐ How many times? _____ How many births? _____

If yes, when have you given birth? _____

Are you currently breastfeeding? No ☐ Yes ☐

Gender:

☐ Female	☐ Two Spirit	☐ Prefer not to answer
☐ Male	☐ Transgender	☐ Do not know
☐ Intersexed	☐ Genderqueer	☐ Other: _____

Sexual Orientation:

☐ Heterosexual (straight)	☐ Two-spirit	☐ Do not know
☐ Gay	☐ Queer	☐ Other:_____
☐ Lesbian	☐ Pansexual	☐ Not applicable
☐ Bisexual	☐ Prefer not to answer	

Are you sexually active: No ☐ Yes ☐ How old were you the first time you had intercourse? ___ Years old.

How many sexual partners have you had to date? _____

What are the genders of your partner(s)? _____

When was the last time you had sex? _____ What types: anal ☐ oral ☐ vaginal ☐ other: _____

Are you currently in a relationship: No ☐ Yes ☐ If yes, what type and how long? _____

Have you ever felt pressured to have sex? No ☐ Yes ☐

Have you ever had sex for drugs or money? No ☐ Yes ☐

Do you have any pain or bleeding during or after sex? No ☐ Yes ☐

Have you ever had a sexually transmitted infection? No ☐ Yes ☐ If yes, which one? _____

Have you ever had a Pap test? No ☐ Yes ☐ If yes, when? _____ Result? _____

Have you used birth control before? No ☐ Yes ☐ If yes, which of the following:
☐ Birth Control Pills ☐ Condoms ☐ Patch ☐ Depo ☐ Ring ☐ Other _____

Have you ever used emergency contraception (Morning After Pill, Plan B)? No ☐ Yes ☐

If yes, when? _____

Lifestyle:

Where are you living and with whom? _____

Are you happy with your current living situation? No ☐ Yes ☐

Do you feel safe? No ☐ Yes ☐

Who do you think of as your support people? _____

Do you go to school? (Name of school) No ☐ Yes ☐ _____

Do you work? (Where do you work?) No ☐ Yes ☐ _____

Do you have or have you done any of the following?

☐Tattoos ☐ Electrolysis ☐Body or skin piercing ☐Acupuncture

Do you use tobacco or cannabis? No ☐ Yes ☐ If yes, how often? _____

How do you use it? Vape ☐ Smoke ☐ Edibles ☐ Chew ☐ Capsules ☐ Drops ☐

Do you drink alcohol? No ☐ Yes ☐ If yes, how many drink per week do you usually drink? _____

Do you use other drugs? No ☐ Yes ☐ If yes, what have you used or tried? _____

How often? _____

Would you like help quitting or decreasing use? No ☐ Yes ☐

Financial:

How do you pay for prescription medications? _____

(Example: Self, Non-insured Health Benefits (NIHB), Employment and Income Assistance (EIA), Child and Family Services (CFS), or private insurance.

Is there anything else you think we should know about you? _____

_____

_____

_____

_____

_____

_____ _____

DATE SIGNATURE