

Interim (Annual) History

Name _____ Date of Birth _____ Age _____

Address _____
 Street _____ City _____ State _____ Zip _____

May we send you mail to the above address in a plain envelope? No _____ Yes _____
 How may we contact you Monday through Friday between 8 a.m. and 4:30 p.m.? Email _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Friends Phone (_____) _____ Friends Name _____

Who may we contact in an emergency? Name _____ Phone (_____) _____

Address _____ Relationship _____

Please answer the following questions so that we will know of any changes since your last yearly exam in the Family Planning Program of the DeKalb County Health Department. **SINCE YOUR LAST YEARLY EXAM HERE**, have you had:

- Any pregnancies? No _____ Yes _____ Are you breastfeeding now? No _____ Yes _____
- Medical problems requiring a doctor's care? No _____ Yes _____
- New allergies? No _____ Yes _____
- Are you currently taking any medication? No _____ Yes _____ Prescription medicine? No _____ Yes _____
- Are you having any medical problems or symptoms now that concern you? No _____ Yes _____

Comments:

Have your **parents, brothers or sisters** developed any of the following?

- Heart attack before age 50? No _____ Yes _____ _____
- High blood pressure? No _____ Yes _____ _____
- High cholesterol? No _____ Yes _____ _____
- Diabetes? No _____ Yes _____ _____
- Cancer of breast, cervix, uterus or ovaries? No _____ Yes _____ _____

- Do you smoke? No _____ Yes _____ If yes, how much? _____
- Do you drink alcoholic beverages? No _____ Yes _____ If yes, what/how much/how often? _____
- Do you now or have you ever used illegal drugs? No _____ Yes _____ If yes, what and how often? _____

What method of birth control are you using now? _____
 Are you having problems with this method? No _____ Yes _____
 Do you want to continue using this method? No _____ Yes _____
 If not, what method do you want to use?

What was the first day of your last menstrual period? Month _____ Day _____ Year _____
 Have you been having any irregular bleeding? No _____ Yes _____ Missed periods? No _____ Yes _____
 Any chance that you might be pregnant now? No _____ Yes _____

Do you have sex with: Males _____ Females _____ Both _____ How many sexual partners have you had in the last year? _____
 Have you been diagnosed with a sexually transmitted infection in the past three years? No _____ Yes _____
 Have you changed sex partners in the past three months? No _____ Yes _____
 Have you and/or your partner(s) had: Oral sex _____ Anal sex _____ Vaginal sex _____
 What are you doing to protect yourself from AIDS? _____

Are you in a relationship with a person who physically hurts or threatens you? No _____ Yes _____
 Do you feel that any of your partners have put you at risk for an STD or HIV? No _____ Yes _____
 Have you ever had a sex partner with a history of injected drug use? No _____ Yes _____
 Do you have sex with men who have sex with men? No _____ Yes _____

Do you have any other problems or concerns we should be aware of today? No _____ Yes _____
 I acknowledge that the above information is correct and complete.

Intake Staff Signature _____ With _____ Client Signature _____ Date _____