ADOLESCENT/ADULT ASSESSMENT RECORD

Male/Female

*Age _____ *Program/Visit Type(s) _____/_____

*Deferred Physical Y__ N __ Reason _____

*Medication Allergies _____

*Medications (Rx, herbals, OTC) _____

*Reason for Visit/ Complaints _____

HEALTH HISTORY - PATIENT

Pap Smear Status

*Pap Smear History (Minimum of last 3 results if applicable) _____

If abnormal history, were records requested _____Yes. If No, why _____

History of Colposcopy/Treatment: LEEP/Cone Biopsy _____

Indicate if high risk factors exist:

❑ HIV positive ❑ Immunosuppressed ❑ DES exposure

❑ Previous Txm for CIN 2, 3 or cancer per colposcopy/pathology

Pap Deferred Today: ❑ Yes ❑ No; If yes, reason _____

Next smear due _____

General Medical History

❑ 1. Adopted
❑ 2. Anemia
❑ 3. Asthma
❑ 4. Autoimmune Disease
❑ 5. Blood Disorder/ Hemophilia
❑ 6. Blood Transfusion Date _____
❑ 7. Cancer
❑ 8. Diabetes
❑ 9. Domestic Violence
*❑ 10. Drug Use - amt/day ____
Alcohol Use - amt/day ____
Tobacco Use - amt/day ____
❑ 11. Fibroid Tumors
❑ 12. GI Disorder
❑ 13. Headaches
❑ 14. Heart Attack/Stroke/Blood Clots
❑ 15. Hypertension
❑ 16. IMM up to date ❑ Yes ❑ No
❑ 17. Kidney Disease
❑ 18. Liver Disease/Hepatitis
❑ 19. Mammogram/Ultrasound:
Date of Last _____
Abn. Result _____
❑ 20. Mental Health Disorder
❑ 21. Other illnesses
❑ 22. Seizure Disorder
❑ 23. Surgery/Hospitalization
❑ 24. Thyroid Disease

Comments _____

Family History - indicate applicable relative in comments section below (i.e., MGM. PGF, Sister, etc.)

❑ 25. Cancer: breast, colon, ovarian, prostate, etc. (indicate age of onset)
❑ 26. Colorectal Polyps
❑ 27. Diabetes
❑ 28. Heart Attack/Stroke/Blood Clots
❑ 29. Hereditary Disease: sickle cell disease, cystic fibrosis, thalassemia, hemophilia, etc.
❑ 30. Hypertension
❑ 31. Mental Health Disorder
❑ 32. Other

Comments _____

*OB/GYN History

Menarche_____LMP_____
G_____P_____Term_____
Premature _____Ab_____
Living _____
Last delivery date_____
Pregnancy complications_____

Contraceptive History – Previous:

List Methods Previously Used _____

Did pregnancy occur while using method?
❑ Yes ❑ No If yes, which method and why did it fail? _____

Contraceptive History – Current:

Breastfeeding: ❑ Yes ❑ No
*Method: _____ Problems _____

Date method last used_____
Method desired _____

*Sexual / Partner History

Pregnant ❑ Yes ❑ No
STD Symptoms: ❑ Yes ❑ No
Prior STDs / Dates Treated _____

Partner: ❑ Males ❑ Females ❑ Both
Partner Drug History: ❑ Yes ❑ No
Partner STD History: ❑ Yes ❑ No
Multiple Partners (past 90 days) ❑ Yes #___ ❑ No
New Partner (past 90 days) ❑ Yes #___ ❑ No
# of Lifetime Partners _____
Last Sexual Exposure: _____ days ago
Exposure Sites ❑ Genital ❑ Anal ❑ Oral
Condom Use ❑ Yes ❑ No DIS Interview # _____
Comments _____

Additional comments if applicable_____

Nurse Signature/Date _____ Student/Translator Name or #_____

Additional comments if applicable_____

History Obtained ❑ History Reviewed ❑ _____ _____

Method Consent Obtained ❑ Provider Initials/Signature Date

*Complete only the asterisk items for STD visits

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