Specialty Care Clinic-History Update [Place patient label here]

Today's Date: _____

Allergies: _____

Medications Have there been any changes to the medications that you are taking? (If yes, please list below)

_____

_____

Have you had any new medical problems since the last time you were seen by a medical provider at Specialty Care Clinic? (If yes, please list problems)

_____

_____

Have you had surgery since the last time you were seen by a medical provider at Specialty Care Clinic? Type of Surgery? What Hospital? -

_____

_____

Are you currently having any health concerns? If yes, please list your concerns/symptoms.

_____

_____

_____

Pregnancy/Gyn History: **[ ] Not applicable/male**

Current Birth Control: _____ Last Menstrual Period Start Date: _____

Problems with Cycle: _____

When Was Your Last Pap Smear? _____ Was it: Normal [ ] Abnormal [ ]

Sexual History:

Ever been sexually active? Y / N Currently sexually active? Y / N

# of partners in past 60 days _____ # of partners in the last year _____

Date of last sexual activity: _____ Partners: [ ] Male [ ] Female [ ] Other

Have your partner(s) recently been treated for a STI? Y / N Partner symptomatic? Y / N

Sites of Exposure: [ ] Oral [ ] Vaginal [ ] Penis [ ] Anus What percent of the time do you use condoms?_____

Comments: _____

Social History: Select all that apply.

Tobacco Use [ ] How often? _____How much? _____How long? _____

Recreational Drugs [ ] How often? _____How much? _____How long? _____

Alcohol use [ ] How often? _____How much? _____How long? _____

Comments: _____

Reviewed By: _____Date: _____ SCC Revised 3/2023