obria MEDICAL CLINICS

Intake Form
Pregnancy & STD/STI

MRN:
(Office Use Only)

Name:	Date of Birth:	Date:

Do you have any allergies (e.g. Latex, Penicillin, etc.)? ( ) Yes ( ) No
*If yes, please list:*_____ *Reaction:* _____
What medications are you taking (including dosage)?
_____
Do you have any diagnosed medical conditions (e.g. Asthma, Diabetes, Hypertension, etc.)? ( ) Yes ( ) No
*If yes, please list:*_____
Do you currently (select all that apply): ( ) Smoke cigarettes ( )Use alcohol (# per week: _____)
( )Use drugs (specify: _____) ( ) N/A
How old were you when you became sexually active? _____ years old
Do you currently feel safe at home? ( ) Yes ( ) No
Have you ever been a victim of abuse: ( ) No ( ) Yes (select all that apply): ( ) Mental/Verbal ( ) Physical ( ) Rape ( ) Sexual
If you have been a victim of abuse, it has:
( ) Been reported and resolved ( ) Not been reported, but is resolved ( ) Not been reported or resolved
What do you typically do to prevent STDs? _____
What do you typically do to prevent unplanned pregnancy? _____

Pregnancy Intake ( ) I Am Not Here for Pregnancy Testing (skip to STD Section)

1st Day of Last Menstrual Period: _____ **Do you currently have an intrauterine device (IUD) in place?** ( ) Yes ( ) No
Was your last period normal? ( ) Yes ( ) No **Are your periods usually normal?** ( ) Yes ( ) No
Symptoms (check all that apply):

( ) Nausea	( ) Vomiting	( ) Sore or Swollen Breasts	( ) Frequently Tired
( ) Frequent Urination	( ) Headaches	( ) Mood Changes	( ) Appetite Change
( ) Dizziness	( ) Weight Gain	( ) Weight Loss	( ) Other: _____

If I have a positive test, I am considering: ( ) Abortion ( ) Parenting ( ) Adoption ( ) Undecided
If considering abortion, would you like Chlamydia/Gonorrhea testing today? ( ) Yes (complete the STD Section below) ( ) No
Total Pregnancies #: _____ **Children #:** _____ **Ages**: _____
Abortions: Spontaneous (Miscarriage) #: _____ Induced (Abortion) #: _____ Ectopic #: _____
Have you already taken a pregnancy test? ( ) No ( ) Yes **Results:** ( ) Positive ( ) Negative ( ) Inconclusive
Have you ever had a bilateral tubal ligation? ( ) Yes ( ) No
Do you have any piercings from the chest down? ( ) Yes ( ) No *If yes, where?* _____

STD/STI Intake ( ) I Am Not Here for STD/STI Testing

What tests would you like to have done? Urine Sample: ( ) Chlamydia ( ) Gonorrhea
Blood Sample: ( ) HIV ( ) Syphilis
Have you ever been tested for a sexually transmitted disease? ( ) No ( ) Yes (Date last tested? _____)
Has a past/current partner notified you that you may have been exposed to an STD/STI? ( ) Yes ( ) No
If yes, which STD/STI? ( ) Chlamydia ( ) Gonorrhea ( ) Hepatitis ( ) Herpes ( ) HIV ( ) HPV ( ) Syphilis ( ) Trichomoniasis ( ) Unknown
Are you currently experiencing any symptoms? ( ) Yes ( ) No
Have you ever been told you tested positive for an STD? ( ) Yes ( ) No
If yes, which STD/STI? ( ) Chlamydia ( ) Gonorrhea ( ) Hepatitis ( ) Herpes ( ) HIV ( ) HPV ( ) Syphilis ( ) Trichomoniasis ( ) Unknown
Have you ever (select all that apply): ( ) performed oral sex ( ) received oral sex ( ) had vaginal sex ( ) had anal sex
Have you been sexually active within the last 3 months? ( ) Yes ( ) No
How many partners have you had in your lifetime? #: _____
Have your sexual partners been: ( ) Male ( ) Female ( ) Both
Do you currently have a primary sexual partner? Yes ( ) No
Is any of your sexual activity ever combined with the use of drugs or alcohol? ( ) Yes ( ) No
Who usually initiates your sexual activities? ( ) You ( ) Partner ( ) Both