**Health Care Screening Tool**

Client Name: \_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Last Menstrual Cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure: Weight: Height: \_\_\_\_\_\_\_ Body Mass Index:

Medications: \_\_\_\_\_

 \_\_\_\_\_

 \_\_\_\_\_

Allergies: \_\_\_\_\_

 \_\_\_\_\_

Chief Complaint Today: \_\_\_\_\_

 \_\_\_\_\_

**Medical History:**

1. Do you have any health problems that you know of?

 \_\_\_\_\_

1. Do any of the following conditions run in your family?
	* Diabetes (sugar problems)
	* High blood pressure
	* Cancer
2. Have you had any issues or problems with:

|  |  |
| --- | --- |
| * Bowel movements (constipation or diarrhea)
* Headaches
* Hearing
* Menstruation (periods)
 | * Stomach (heartburn, nausea, vomiting)
* Urination (peeing)
* Vision
 |

1. Have you ever been pregnant? \_\_\_\_\_\_

How many times pregnant? \_\_\_\_\_\_ How many births? \_\_\_\_\_\_

How many miscarriages or abortions? \_\_\_\_\_\_ C-section or Vaginal Births? \_\_\_\_\_\_

1. Do you use birth control? \_\_\_\_\_\_ If yes, what kind? \_\_\_\_\_\_\_\_\_\_
2. Last Pap smear in a doctor’s office? \_\_\_\_\_\_\_\_\_\_
3. Mammogram? (over 40) \_\_\_\_\_\_\_\_\_\_
4. Have you ever been treated for depression? \_\_\_\_\_\_
5. Have you ever had seizures? \_\_\_\_\_\_
6. Have you had a flu shot this year? \_\_\_\_\_\_
7. Do you smoke cigarettes? \_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_

Are there any health topics you would like more information on?

 \_\_\_\_\_

Referral? \_\_\_\_\_

Interviewer: Date:

Developed by the Haven Shelter & Services, Inc. in Warsaw, Virginia and adapted by the Virginia Sexual and Domestic Violence Action Alliance