

**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