

Do you get along with your family? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you having a hard time with the people you live with? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a friend you can talk to about any problems you have? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you having a hard time with friends including your boyfriend or girlfriend? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you having trouble with fighting or bullying? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you feeling pressure to do what others are doing? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been a victim of threats, physical hurting, or forced sexual contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
During the past 2 years, have you, or has anyone in your family, had any major good or bad changes? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain: Do you have any concerns about your body or weight? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you ever eat in secret or feel guilty about eating? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you ever make yourself throw up? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever used tobacco or nicotine products (cigarettes, chew, e-cigarettes, vaping device)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: Complete Tobacco History section in Epic
Are you attracted to: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both <input type="checkbox"/> Non binary people <input type="checkbox"/> No one Have you ever had sex? <input type="checkbox"/> Yes <input type="checkbox"/> No - skip to next section Have your sexual partners included: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Transmen <input type="checkbox"/> Transwomen <input type="checkbox"/> Non-binary people Did you use condoms or other barrier during sex? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never How many sexual partners have you had in the last 3 months? _____ Have you been tested for HIV? <input type="checkbox"/> No <input type="checkbox"/> Yes Are any of your current sexual partners known to be HIV positive: <input type="checkbox"/> Yes <input type="checkbox"/> No When you have sex, how often do you, or does your partner, use protection from pregnancy other than a condom? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Doesn't apply to me If you or your partner use protection, what kind: <input type="checkbox"/> Condoms <input type="checkbox"/> Birth control pills <input type="checkbox"/> IUD <input type="checkbox"/> Depo-Provera <input type="checkbox"/> Other: _____ Many sexually transmitted infections (STI) do not have symptoms you can see or feel. That's why it's important to get tested if you could be at risk. Places that could be infected by an STI include the genitals, anus, throat, and mouth. When we screen for STIs, we routinely test all sites that could be infected. Are there any sites you don't want me to check? <input type="checkbox"/> No <input type="checkbox"/> Yes	If YES to "ever had sex", give handout on Routine HIV Testing
Menstrual, Pregnancy History	
How old were you when your periods started? _____ Are your periods regular? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply to me When was your most recent period? _____ <input type="checkbox"/> Doesn't apply to me Do menstrual cramps keep you from doing normal activities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply to me Are you: <input type="checkbox"/> On birth control that prevents periods <input type="checkbox"/> Taking gender affirming hormones that prevent periods <input type="checkbox"/> None of these Are you pregnant or planning to get pregnant within the next year? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, are you taking a daily supplement that has folate (folic acid)? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have been pregnant: Number of full-term pregnancies: ____ Number of miscarriages or abortions: ____	If yes to pregnant: Enter in OB History section of Epic.

Medical and Surgical History	
Please list any major illnesses, injuries, or conditions that were treated outside Kaiser Permanente that you haven't told us about in the past. <input type="checkbox"/> None	Provider or RN Enter major illnesses, injuries, or conditions into PMH section or Problem List in Epic as appropriate. Enter major surgeries into PSH section in Epic.
Please list any major surgeries performed outside Kaiser Permanente that you haven't told us about in the past. List each one and the approximate year. <input type="checkbox"/> None	
Personal and Family History (those related to you by blood)	
Do you have a personal or family history of breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know If YES, please describe (ie: you, which family member):	If YES, give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRQ).
Did any of the following family members develop heart disease? Check all that apply. <input type="checkbox"/> Before age 55: father, brother, or son <input type="checkbox"/> None before age 55 <input type="checkbox"/> Don't know <input type="checkbox"/> Before age 60: mother, sister, or daughter <input type="checkbox"/> None before age 60 <input type="checkbox"/> Don't know	
Have you ever had Crohn's disease, ulcerative colitis, colon polyps, or colon cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: Consult GI.
Have you had a mother, father, sister, brother, daughter, or son diagnosed with the following? Colon cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age: ____ <input type="checkbox"/> Don't know Colon polyps: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age: ____ <input type="checkbox"/> Don't know Have you had a grandparent, aunt, uncle, niece, or nephew diagnosed with the following? Colon cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age: ____ <input type="checkbox"/> Don't know If YES to either question above, please circle the relative(s) with the condition.	If YES to family history: See Colorectal Cancer Screening Guideline for screening recommendations.
Do you have a personal or family history of ovarian cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know If YES, please describe (ie: you, which family member):	If YES, give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRQ).
Advanced Care Planning	
Do you have a signed Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Do you have an up-to-date Durable Power of Attorney for health care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	If documents are presented, send for scanning to Advance Directives Registry.