

Tobacco, Nicotine Use	
Have you ever used tobacco or nicotine products (cigarettes, chew, e-cigarettes, vaping device)? <input type="checkbox"/> No <input type="checkbox"/> Yes	If YES: Complete Tobacco History section in Epic
Sexuality	
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 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 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 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: _____ Surgical method: <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Hysterectomy Do you have any concerns about your sexual health or pleasure? <input type="checkbox"/> No <input type="checkbox"/> Yes 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 NO to HIV testing, give handout on Routine HIV Testing
Menstrual, Pregnancy History	
Do you have a uterus? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant or do you plan 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 yes : Number of full-term pregnancies: ____ Number of miscarriages or abortions: ____	STAFF: Enter using dot phrase .wq22to64 If yes to pregnancy: Enter in OB History section of Epic.
If you're still menstruating, when was your last period (date): _____ Please describe your periods: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Heavy <input type="checkbox"/> Painful	
If you're no longer having periods: Are you: <input type="checkbox"/> Menopausal <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 taking a daily supplement that has both vitamin D and calcium? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any bleeding since you stopped having periods? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have pain with intercourse or orgasm? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is urination or leaking urine a problem for you? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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	STAFF: 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 doc 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.