Carroll County Health Department
Reproductive Health Services
Problem Visit History Form

You are scheduled for a problem focused visit on _____ (date). So that we can give you the best care possible, please answer the following questions as soon as possible. You can email the form or the answers to cchd.reprohealth@maryland.gov

First and Last Name: _____

Date of Birth: _____ Date you completed this form: _____

What is the reason for your visit?

_____

Do you take any medications (prescription or over the counter)? NO ☐ YES ☐

If yes, please list them:

_____

Are you allergic to any medications? NO ☐ YES ☐
If yes, what are you allergic to and what happens?

_____

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What type of symptoms or problems are you experiencing? Check all that apply

☐ Itching ☐ Burning ☐ Discharge ☐ Pain ☐ Rash/Sore/Spot

☐ Pain or bleeding with sex ☐ Abnormal period/vaginal bleeding

Other: (please explain)

Have you recently been exposed to an STD or HIV? NO ☐ YES ☐
If yes, which ones?

Any new partners in the last 6 months? NO ☐ YES ☐

When was the last time you had sex? (date).

Did you use a condom? NO ☐ YES ☐

If appropriate, when was the first day of your last menstrual period: (date).