



Welcome to Planned Parenthood. These questions will help us assess your health needs. This is a confidential record of your history.

Name _____ Today's date _____ Birthdate _____

List any allergies you have including medications, metals, latex & what reaction they cause _____

Reason for your visit _____ Age _____

MENSTRUAL HISTORY

When was the first day of your last menstrual period? _____ How many days does it usually last? _____

How old were you when your periods started? _____ Are your periods regular? _____

Yes No

- Was your last menstrual period on time and normal?
Are you concerned that you could be pregnant?
Do you have severe cramps with your periods?

Yes No

- Do you bleed between periods?
Have you had intercourse since your last period?
Do you douche? If yes, how often? _____

CONTRACEPTIVE HISTORY

When you have intercourse, do you use a method of birth control? Yes No. If yes, what? (include tubal ligation or partner sterilization) _____ For how long have you used this? _____

If you have had problems with this method or others, please explain _____

Do you want a method of birth control today? If so, what? _____

List all methods of birth control you have used: _____

PREGNANCY HISTORY

Never pregnant (skip to the next section)

Age at first pregnancy _____ Number of: Total pregnancies _____ Live births _____ Vaginal deliveries _____

Cesarean sections _____ Living children _____ Ages? _____ Premature births _____ Miscarriages _____

Abortions _____ Stillbirths _____ Ectopic (tubal) Pregnancies _____ Any genetic abnormalities? _____

Describe _____ Are you breast feeding now? Yes No

PAST MEDICAL HISTORY

Have you ever had surgery, been a patient in a hospital or had a major illness? yes No

If yes, explain _____

List all current medical problems _____

List all medications or drugs you are now taking or take often including over-the-counter medications, herbal medications and vitamins _____

List all your other sources of health care (doctors, clinics, etc) _____

When and where was your last pelvic exam and pap smear? _____

Have you had or do you now have: (please check each item)

Yes No

- Cancer
Stroke
Heart disease or high blood pressure
Thrombophlebitis/Blood clot(s) in veins or lungs
Liver disease/Hepatitis; Which type?
Mononucleosis When?
Sickle cell disease/trait or Thalassemia

Yes No

- Breast surgery or disease
Diabetes/diabetes in pregnancy
Abnormal Pap Smear
Pelvic infection/PID
Many vaginal infections
Endometriosis or ovarian cysts
Frequent bladder infections

Yes No

- Gall Bladder disease
Tuberculosis
Arthritis
Genetic condition
Rubella (German Measles)
Blood transfusion
Osteoporosis (brittle bones)

FAMILY HISTORY If you are ADOPTED & do not know your family's medical history, check here & skip this section.

Indicate which people in your family have had any of the following illnesses (F)father, (M)mother, (B)brother, (S)sister

Blood clot(s)
Diabetes
High Cholesterol
High Blood Pressure
Stroke, Heart Attack, Heart Disease; age of onset:
Breast, Ovarian or Uterine Cancer; age of onset:
Other Cancer
Osteoporosis (brittle bones)

SOCIAL HISTORY

Yes No

- Do you smoke or use tobacco? If so, how much per day? _____
- Do you drink alcohol? If so, how often/how much? _____
- Do you or your partner use street or IV drugs? If so, what? _____
- Does drug or alcohol use influence your ability to practice safer sex?
- Would you like to receive information on where to get help for a drug or alcohol problem?
- Do you exercise regularly?
- Do you have concerns about your weight or eating habits that you would like to discuss today?
- Are you planning future pregnancies?

SEXUAL HISTORY

These questions may seem personal but they help us to evaluate your health. All information is confidential. Please answer only the questions you are comfortable answering.

Yes No

- Have you had sexual intercourse? Age 1st time _____
- Are you currently in a sexual relationship? Is your sexual contact: all that apply Vaginal Anal Oral
- Have you had more than 1 partner in the past year? Are your partner(s) Male Female Both
- Do you practice safer sex? Explain how _____
- Do you feel you have any current behavior that puts you at risk for becoming infected with HIV or any other sexually transmitted infections? If yes, explain _____
- Not sure** Do you want to be tested for sexually transmitted infections and/or HIV?
- Do you want to discuss problems related to a rape or other sexual or physical abuse today?
- Not sure** Do you have any questions or concerns about sex or your sexuality that you would like to discuss today?

REVIEW OF SYSTEMS

Have you had or do you now have any of the following (please check each item):

1. General

Yes No

- My health is generally good
- Recent \geq 25 lb weight gain or loss
- Hot flashes

2. Immunizations

- Rubella (German Measles)
- Vaccine/shot for Rubella/MMR
- Hepatitis B vaccination
- Hepatitis A vaccination
- HPV vaccine (Gardasil)

3. Cardiovascular

- Mitral Valve Prolapse
- Palpitations/Heart Murmur
- Varicose Veins

4. Neurologic

- Diagnosed migraines
- Other severe headaches
- Persistent numbness, tingling
- Seizures/Epilepsy

5. Gastrointestinal

Yes No

- Stomach or bowel problems

6. Eyes

- Eye problems (other than glasses or contact lenses)

7. Respiratory

- Chronic cough
- Breathing problems/Asthma

8. Hematologic

- Anemia/low iron
- Blood Clotting Disorder

9. Genitourinary

- Bladder, kidney or urinary problems
- Uterine Fibroids
- Sexually transmitted infections: **circle** Chlamydia, Gonorrhea, Herpes, HIV Syphilis, Genital warts, Other
- Breast lump or nipple discharge

10. Musculoskeletal

Yes No

- Arthritis

11. Skin

- Acne
- Chronic rash
- Other skin problems
- allergies or irritants

12. Endocrine

- Thyroid problems

13. Ears, Nose, Throat, Mouth

- Hearing problems
- Frequent nosebleeds
- Frequent sore throat

14. Psychology

- Depression
- Anxiety or mood swings
- Under the care of a psychiatrist/therapist

To the best of my knowledge, the information on this history form is complete and correct.

Client signature _____ Date _____

Clinician signature _____ Date _____ Rev 12/07