

**Planned Parenthood of Central North Carolina, Inc. ~ Toll Free 1-866-942-7762**

Chapel Hill Health Center  
1765 Dobbins Drive  
Chapel Hill, NC 27514

Durham Health Center  
105 Newsom Street, Suite 101  
Durham, NC 27704

Fayetteville Health Center  
4551 Yadkin Road  
Fayetteville, NC 28303

**Comprehensive Medical History**

<b>Name:</b>	<b>Preferred name:</b>	<b>Date:</b>
<b>Patient number:</b>	<b>DOB:</b>	<b>Age:</b>
I am here today because:		

Please answer the following questions:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently being treated for any illness or condition? Please describe:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under the care of a primary care provider or family physician?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a serious illness? Please describe:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Have you ever had a blood clot (head/heart/lungs/legs)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you have a blood clotting disorder or easy bleeding disorder?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Have you ever had a stroke or stroke-like problems?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Have you ever had a heart attack or chest pain?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Have you ever had liver problems (hepatitis, liver tumor or other)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you use tobacco?</b> If yes, how many years? ____ If smoking, how many per day? ____ <input type="checkbox"/> Chewing tobacco?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you get tension or stress headaches?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you get migraine headaches?</b> Migraine headaches are strong, recurring headaches that may make you have nausea and sensitivity to light.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If you do get migraines, do you ever have vision changes that</b> <input type="checkbox"/> start before the headache <input type="checkbox"/> last up to one hour <input type="checkbox"/> resolve before the headache begins
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an eating disorder? If yes, please indicate <input type="checkbox"/> now <input type="checkbox"/> past
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have night sweats or hot flashes?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use alcohol? If yes, how many drinks per week?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use street drugs? Which type(s):
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do alcohol or drugs cause problems in your life? Are others concerned with your alcohol/drug habits?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently take medicine: prescription, over-the-counter, or herbal? Please list:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking a daily multivitamin which includes folic acid?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you allergic to any drug, medication, latex or other substance, including local anesthesia? Please list:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had surgery? Please describe:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you transgender? Preferred pronoun: <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> Self-identify:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have mitral valve prolapse or a heart murmur?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had high blood pressure?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had high cholesterol?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a chronic cough or other breathing problems/asthma?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have stomach or bowel problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have problems with recurrent urinary tract infections, kidney infections or bladder leaks?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Planned Parenthood recommends regular HIV testing. Would you like to have an HIV test today?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a sexually transmitted infection? Check type: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Genital warts/HPV <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> PID <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Trich
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have unusual itching, sores or bumps in your genital area?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have changes to or problems with libido or sex drive?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have seizures/epilepsy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been treated for depression?
<input type="checkbox"/> Yes <input type="checkbox"/> No	During the past month, have you been bothered by feeling down, depressed, hopeless or anxious?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have thyroid problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have diabetes? If yes, how many years since your diagnosis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have anemia?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have birth defects or genetic problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did your mother take DES when she was pregnant with you? (only if you were born before 1971)
<b>Immunizations (check the ones received)</b>	
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3
<input type="checkbox"/> Measles/mumps/rubella	<input type="checkbox"/> Diphtheria/tetanus <input type="checkbox"/> HPV vaccine <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3 <input type="checkbox"/> Don't know

<b>Family history</b>		Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have your biological family (parents, brothers, sisters) ever had one of the following? If yes, please list which relative.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease/heart attack/stroke before age 50		
<input type="checkbox"/> Yes <input type="checkbox"/> No	High cholesterol		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Genetic problems		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer. If yes, please specify:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood clots or blood clotting disorder		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:		
<b>Sexual history</b>		<input type="checkbox"/> Not currently sexually active	
Sexual partner(s): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both			
Sexually active: <input type="checkbox"/> Anal <input type="checkbox"/> Oral <input type="checkbox"/> Vaginal			
<input type="checkbox"/> New sex partner in the past 6 months		<input type="checkbox"/> Partner currently has other sex partner(s)	
<input type="checkbox"/> Sex since last period without birth control/condoms (if applicable)			
<b>Contraceptive history</b>			
<input type="checkbox"/> Birth control not needed because _____		(skip to next section)	
Current birth control method:		How long used?	
Any problems with this method? If yes, please describe:			
What method do you want to use now?			
What types of contraception have you used in the past? Please note any problems.			
<b>Social history</b>			
Planned Parenthood must report to appropriate agencies incidences of child abuse or neglect or suicidal intentions as required by law.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you recently had a major life stress or life change?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been physically or emotionally abused by your partner or someone important to you?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been hit, slapped, kicked or otherwise physically hurt by someone in the past year?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has anyone forced you to have sex in the past year?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you afraid of your partner or anyone listed above?		
For women who have sex with men:			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your partner ever hidden or destroyed your birth control?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your partner refuse to use condoms when you ask?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your partner ever tried to force or pressure you to become pregnant when you didn't want to be?		
Please circle answer:			
In the past year: My partner threatened or frightened me: never, seldom, sometimes, often			
In the past year: My partner hit, slapped, or physically hurt me on purpose: never, seldom, sometimes, often			
<b>Reproductive health history</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Have you ever had inguinal, scrotal or vasectomy surgery?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Have you ever had a scrotal skin infection?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Do you have discharge from your penis or burning with urination?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Have you had changes in your testicles or swollen glands?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Do you have uterine fibroids, ovarian cysts or uterine abnormality?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Do you have a breast lump or nipple discharge?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Do you have pelvic pain?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Do you have pain or bleeding with sex? Other sex problems?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Do you have unusual vaginal discharge?		
When was your last Pap test?		Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Never had a Pap test	
<input type="checkbox"/> Not applicable			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an abnormal Pap test? Please describe:		
<b>Pregnancy history</b> <input type="checkbox"/> Not applicable (skip section) <input type="checkbox"/> Never pregnant <input type="checkbox"/> Currently pregnant, number of weeks:			
# of pregnancies total _____	# of miscarriages _____		
# of living children _____	Children's ages _____		
# of C-sections _____	# of vaginal births _____		
# of abortions _____	Complications: _____		
Date last pregnancy ended: _____	Currently breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an ectopic pregnancy?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you planning a pregnancy in the next year?		
<b>Menstrual history</b> <input type="checkbox"/> Not applicable (skip section) <input type="checkbox"/> No longer have periods			
First day of your last period:		Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Age periods began:	
Your periods are: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular			
		Periods come every _____ days and last _____ days	
Cramping is: <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Tolerable <input type="checkbox"/> None		Bleeding is: <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have problems with your period?		

To the best of my knowledge, the above information is complete and accurate. This form is good for two years.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_