

DOB

Planned Parenthood of Central North Carolina, Inc.

Chart #

Toll Free 1-866-942-7762

1765 Dobbins Drive
Chapel Hill, NC 27514105 Newsom Street, Suite 101
Durham, NC 277044551 Yadkin Road
Fayetteville, NC 28303**MEDICAL HISTORY FORM**

First Name: _____ Last Name: _____

How did you learn about PPCNC's abortion services? _____

Have you had a positive pregnancy test? yes no First day of your last normal period: _____

When was your last physical exam that included a pap smear and breast check? _____

If you are over 40, when was your last mammogram? _____

Do you have any concerns today about being at risk for a sexually transmitted infection? yes no

Have you had a change in sexual partners in the last 6 months? yes no

Has anyone forced you to have sex or sexual contact? yes no

Has anyone hurt you or are you currently afraid of being hurt? yes no

How many times have you been pregnant before now? _____ Any complications? yes no

How many of each of the following have you had?

____ vaginal delivery ____ abortion ____ miscarriage ____ c-section ____ ectopic pregnancy

When did your last pregnancy end? _____

What birth control methods have you used in the past? condoms pills patch vaginal ring Depo Provera
emergency contraception diaphragm/cervical cap IUD withdrawal other: _____

What problems have you had with birth control methods? _____

What method were you using when you got pregnant? _____

Which method are you interested in using now? _____

Are you or your partner interested in permanent birth control? Essure Tubal Occlusion Vasectomy Other

Are you taking/using any of the following?**inhaler blood thinners steroid pills herbal supplement medication (name) _____****Are you allergic to any of the following?****latex iodine shellfish aspirin/ibuprofen (NSAIDS) Tylenol (acetaminophen) Other?****What is your approximate current weight? _____ lbs.****Do you smoke? yes no How much per day? _____**

Do you use street drugs? yes no Which ones? _____

Have you had any surgery? yes no What type? _____

Please check any of the following conditions you have now or have had in the past:

	Now	Past		Now	Past
Abdominal or pelvic pain			Heart attack/chest pain		
Abnormal pap smear			Heart murmur/problem		
Anemia			High blood pressure		
Asthma/chronic bronchitis			High cholesterol		
Bladder/kidney infection			Leg or lung blood clots		
Blood clot disorder/phlebitis			Liver disease or tumor		
Brain tumor			Pelvic inflammatory disease		
Breast lump			Rheumatic fever		
Cancer			Seizures/epilepsy		
Chronic adrenal failure			Sexually transmitted infection		
Depression			Steroid therapy, long-term		
Diabetes			Stroke, or family history of		
Digestive problems			TB, Tuberculosis		
Easy bleeding disorder			Thyroid problems		
Gallbladder disease			Unusual vaginal discharge		
Genetic disorder			Vaginal infection		
Headache/migraine			Other:		

To the best of my knowledge, this medical history is accurate and complete.

Patient Signature: _____ Date: _____

HCA Signature: _____ Date: _____

MD/Clinician Signature: _____ Date: _____