Planned Parenthood of Kentucky
Client Name: Chart # Today's Date
Date of Birth

Please answer the following questions:

What is the main reason for your visit today?_____

Are you allergic to any medicines, shellfish, or copper? ☐ No ☐ Yes, which ones_____

Do you take (or are supposed to take) medicines, natural remedies, aspirin, or other drugs? ☐No ☐Yes

If yes, list them:_____

No	Yes	Have you ever had or do you currently have:	No	Yes	
☐	☐	Diabetes	☐	☐	Problems with your kidneys or bladder
☐	☐	Seizures	☐	☐	Bone disease or weak bones
☐	☐	Heart attacks or strokes	☐	☐	Cancer
☐	☐	High blood pressure	☐	☐	Breast surgery or problems
☐	☐	Depression	☐	☐	Pelvic infection treated in the hospital
☐	☐	Migraines or bad headaches	☐	☐	Uterine fibroids or ovarian cysts
☐	☐	Blood clot in your blood vessels like the leg or lung	☐	☐	Eczema or bad skin rashes
☐	☐	Hepatitis or gallbladder problem	☐	☐	Ectopic or tubal pregnancy
☐	☐	Other serious medical condition, surgery, or hospitalization	☐	☐	Blood transfusions or IV drug use

Are you adopted? ☐ No ☐ Yes

Has anyone in your **immediate** family (mother, father, sister, brother, daughter, son) had any of the following:

	No	Yes	If yes, who:
Cancer……...	☐	☐	_____
Diabetes……..…	☐	☐	_____
Heart attack, stroke or high blood pressure…….	☐	☐	_____
High cholesterol…….	☐	☐	_____
Blood clots in blood vessels like the leg or lung?……..…	☐	☐	_____

Do you use tobacco? ☐ No ☐ Yes How many per day ?_____ How many years?_____

Do you drink alchohol? ☐ No ☐ Yes How often? ☐ daily ☐ weekly ☐ monthly

How many alcoholic drinks do you have at one time? ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5+drinks

Do you use other drugs (ex: marijuana, cocaine, or IV drugs)? ☐No ☐Yes (this information is confidential and for medical purposes only) What do you use?_____How often? ☐ daily ☐ weekly ☐ monthly

Do you feel safe from violence in your personal relationships? ☐ No ☐ Yes

Have you ever had a sexually transmitted disease or genital infection? ☐ No ☐ Yes

Check the ones you might have had: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital Warts ☐ PID ☐ Syphilis ☐ HIV ☐ Bacterial Vaginosis ☐ Trichomonas ☐ Hepatitis B or C ☐ Yeast

Number of sex partners you had in the last **2 months**_____ **12 months**_____ **Lifetime**_____

Are/Were your partners (check all that apply): ☐ men ☐ women ☐ IV drug users ☐ bisexual ☐ A partner with multiple sex partners or at risk for HIV or STD infection

How long have you been with your current sex partner(s)?_____Age you first had sex?_____

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What type of sex have you had in the past 2 months? (check all that apply) ☐ vaginal ☐ oral ☐ anal ☐ no sex

Do you have symptoms of a genital infection? ☐ No ☐ Yes (check the ones you have) ☐ Painful/frequent urination

☐ Discharge ☐ Odor ☐ Itch ☐ Rash ☐ Bumps ☐ Sores ☐ Pain with sex ☐ Bleeding after sex ☐ Burning

Have you used a birth control method before: ☐ No ☐ Yes (check the types you have used)

☐ Pills ☐ Condoms ☐ Diaphragm/Cervical Cap ☐ Implant ☐ IUD ☐ Patch ☐ Ring

☐ Shot/Depo ☐ Vasectomy/Tubal ☐ Abstinence ☐ Withdrawal ☐ Suppository/Film/Foam

☐ Natural FamilyPlanning/Rhythm ☐ Other ☐ Emergency Contraceptive Pills

What do you use now?_____

List any problems with your current methods:_____

Are you up to date with your immunizations like Hepatitis, or HPV (Gardasil)? ☐ No ☐ Yes ☐ Unknown

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How old were you when you had your first period?_____ How many days do your periods last?_____

For your most recent period, what was the **first day** bleeding started?_____

How many days from the start of one period until the start of the next period?_____

When was the last time you had sex with a male without birth control? Date:_____

Do you bleed between periods? ☐ No ☐ Yes Do you think you could be pregnant today? ☐ No ☐ Yes

Will this be your first pelvic exam today? ☐ No ☐ Yes Date of your last pap test:_____

Have your pap tests been normal? ☐ No ☐ Yes DES Exposure ☐ No ☐ Yes

If you have had an abnormal Pap test, when, where, and what was done?_____

Have you ever been pregnant? ☐ No ☐ Yes (if no, skip to signature) Are you breastfeeding? ☐ No ☐ Yes

# of pregnancies_____# of deliveries_____# of ectopics_____

# of living children_____# of abortions_____# of miscarriages_____

If you have been pregnant before, when did your last pregnancy end? Date:_____

How many vaginal deliveries?_____How many c-sections?_____

When you were pregnant, did you get diabetes? ☐ No ☐ Yes Have any of your babies been 10 pounds or more? ☐ No ☐ Yes

Client Signature:_____Date:_____

Do not write anything in this space.

History reviewed by:_____Date:_____

Revised 9/08