

PLANNED PARENTHOOD OF GREATER NORTHERN NJ, INC.
ANNUAL VISIT MEDICAL RECORD

PLEASE PRINT

Date: _____

Sex: F M

Name: _____
Last First M.I.

Has your name changed: No Yes Previous name: _____
 Single Married Widowed Divorced

Address: _____
Street Apt. # City State Zip

Date of Birth: ____/____/____ Age: _____ SS#: _____
(M / D / Y)

Check ALL the ways we may contact you

Call Home: phone #: _____

Call Beeper/cell phone #: _____ Best Time: _____

Call Work: phone #: _____

Call Other: _____ Best Time: _____

Can we identify ourselves as Planned Parenthood:
If we call you: No Yes If we write you: No Yes
 Coded Contact What should we say: _____

EMERGENCY CONTACT PERSON (Legal Guardian, if under age 18)

Name: _____ Relationship: _____
Address: _____ Phone: _____

REASON FOR VISIT

I am here today because: _____

Other medical providers seen in the last year: _____

FAMILY HISTORY

Has there been any change since your last visit: No Yes Describe: _____

YOUR HEALTH/WELLNESS LIFESTYLE

Smoking: # cigarettes per day: _____ Is this an increase or decrease in #: No Yes

Do you exercise: No Yes Times/week: _____ Minutes/day: _____

Do you wear: a seat belt in the car No Yes Helmet on a bike, skateboard or skates No Yes

Alcohol: When was the last time you had more than 4-5 drinks in one day Never In the past 3 months
 over 3 months ago

What social/street drugs have you used: _____
How often: _____ Date last used: _____

Date: ____/____/____

Patient Name: _____
Patient Number: _____
Date of Birth: _____

YOUR SEXUAL HISTORY

Are you currently sexually active: No Yes

Number of new sex partners within the past 3 months: _____

More than one sexual partner in the last 12 months: No Yes Unknown

Partners have been: Male Female Both

Sites of sexual contact: oral vaginal anal

Since your last visit have you been exposed to/treated for a sexually transmitted disease: No Yes

Have you ever been physically or sexually abused or raped: No Yes

Date: _____ Was it reported: No Yes

Did you receive counseling: No Yes

Does your partner have a history of sex with the same gender: No Yes Unknown

Do you use condoms: No Yes Sometimes Always

PLEASE ANSWER ALL QUESTIONS (Please Circle)

IF MALE please answer

1. History of Penile discharge: Describe:	Y N	5. Do you examine your testes:	Y N	8. Premature ejaculation:	Y N
2. Hernias	Y N	6. Pain in testes/ scrotum:	Y N	9. Sexual dysfunction/ impotence:	Y N
3. Prostate problems:	Y N				
4. Have you ever had a P.S.A.:	Y N	7. Mass/lump in testes/ scrotum:	Y N	10. Lesions or bumps: How long:	Y N

IF FEMALE please answer

CONTRACEPTIVE HISTORY

Method today: _____

Since your last visit have you had sex without contraception: No Yes

Have you had sex without contraception (including condom accident) in the last 5 days: No Yes

Have you stopped using contraception: No Yes Why: _____

A. Has there been a change in your menstrual periods:	Y N	F. Abnormal uterus: Describe:	Y N	K. Last mammogram:	Date:
B. Last pelvic exam:	Date:	G. History of Vaginal Discharge: Describe:	Y N	L. Sexual dysfunction Describe:	Y N
C. Last PAP:	Date:	H. Lesions or bumps How long:	Y N	M. Intercourse: Do you have pain and/or bleeding:	Y N
D. Abnormal PAP: Describe:	Y N	I. Since your last visit have you had any pregnancies: Outcome:	Y N		Date:
E. Colposcopy/cryo/LEEP/ laser/cone: Describe:	Y N	J. Are you currently breastfeeding:	Y N		

Date: ____/____/____

Patient Name: _____

Patient Number: _____

Date of Birth: _____

A. REVIEW OF SYSTEMS:		
Yes	N O	GENERAL
		1. Is your health generally good?
		2. Unexplained weight loss or gain of more than 10 lbs. in the past year?
		3. Night sweats/hot flashes?
		4. Are you being treated for any illness/condition now? If yes what?
		5. Physical/Emotional Abuse?
		6. Coercion/Rape/Incest?
		7. Have you been hit, kicked, punched or otherwise hurt by someone in the past year?
		8. Do you feel safe in your current relationship?
		9. Is there a partner from a previous relationship who is making you feel unsafe now?
		10. Hearing problems?
		11. Frequent nosebleeds?
CARDIO-RESPIRATORY		
		12. Heart disease?
		13. Varicose veins?
		14. Blood clots (head/leg/lungs)?
		15. Stroke or stroke-like problems?
		16. High blood pressure?
		17. High cholesterol?
		18. Chronic cough or other breathing problems/asthma?
		19. Tuberculosis or exposure to tuberculosis?
GASTROINTESTINAL		
		20. Stomach or bowel problems?
		21. Liver problems (hepatitis or tumor, etc.)?
		22. Gallbladder problems?
		23. Rectal Bleeding/pain/itching?
GENITOURINARY		
		24. Bladder, urine leakage or kidney problems
		25. Pain, burning or frequent urination?
		26. Frequent bedtime urination?
		27. Incontinence?
MUSCULOSKELETAL/RHEUMATOLOGICAL		
		28. Arthritis?

		29. Osteoporosis?
		30. SLE (lupus)
SKIN		
		31. Breast Lump/Discharge?
		32. <input type="checkbox"/> Tattoo? <input type="checkbox"/> Piercing? If yes, where? - _____
NEUROLOGICAL		
		33. Headaches?
		34. Migraine headaches/Aura (diagnosed by MD/NP/PA)?
		35. Seizures/epilepsy?
		36. Numbness in arms/legs (recurring)?
PSYCHOLOGICAL		
		37. Depression requiring treatment? Have you ever considered suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No
		38. Other psychological problems?
ENDOCRINE		
		39. Thyroid problems?
		40. Diabetes?
HEMATOLOGICAL/LYMPHATIC		
		41. Anemia (Low Iron)?
		42. Sickle cell disease/trait?
		43. Blood clotting disorder?
		44. Transfusion of blood/blood products?
IMMUNOLOGIC		
		45. HIV/AIDS?
		46. Cancer?
IMMUNIZATION (Check the ones you have received)		
		47. <input type="checkbox"/> Hepatitis A?
		48. Hepatitis B <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?
		49. Human Papillomavirus (HPV) <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?
		50. <input type="checkbox"/> Measles/Mumps/Rubella (MMR)?
B. HOSPITALIZATION AND SURGERIES		
Year	Reason	
C. ACCIDENTS AND INJURIES		
Year	Reason	

D. FAMILY HISTORY			
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have your biological family (parents, brothers, sisters) had any of the following?			
Yes	N O	Diagnosis	Relative
		Osteoporosis?	
		Diabetes?	
		Heart disease/heart attack/stroke before age 50?	
		High blood cholesterol?	
		Genetic problems?	
		Cancer? If yes, please specify _____	
		Blood clots?	
		Other?	
If you were born before 1972, did your mother take DES NO YES UNKNOWN			
Allergies to: Medications, LATEX, Environment, Food, Other?			
Medications: Including Prescription, over-the-counter, herbals and vitamins:			
Current:		Past 12 Months:	

To the best of my knowledge, the above information is complete and accurate.

Signature of Patient: _____

Signature of Interpreter: _____

Printed Name of Interpreter: _____

Date: ____/____/____

Patient Name: _____

Patient Number: _____

Date of Birth: _____