Planned Parenthood Health Systems, Inc.	☐ Asheville ☐ Lynchburg	☐ Blacksburg ☐ Raleigh	☐ Charleston ☐ Roanoke	☐ Charlotte ☐ Vienna	☐ Charlottesville ☐ Wilmington	☐ Columbia ☐ Greensboro ☐ Winston- Salem

TODAY'S DATE:

A. REVIEW OF SYSTEMS:		
YES	**NO**	**GENERAL**
		1. My health is generally good
		2. Unexplained weight loss or gain of more than 10 lbs
		3. Night sweats/hot flashes
		4. Cancer. If yes, where/when?
		5. Smoke cigarettes. If yes, ____ packs/day, _____ years
		6. Alcohol use. If yes, how may drinks/week?
		7. Birth defects or genetic problems
		8. Are you being treated for any illness/condition now? If yes what?
		9. Do you currently take medicine prescription, over the counter or herbal? If yes, name:
Y	N	**EYES**
		10. Eye problems (except glasses or contacts)
Y	N	**EARS/NOSE/MOUTH/THROAT**
		11. Hearing problems
		12. Frequent nosebleeds
		13. Frequent sore throat
Y	N	**CARDIOVASCULAR**
		14. Mitral Valve Prolapse
		15. Heart murmur
		16. Varicose veins
		17. Blood clots (head/leg/lungs)
		18. Stroke or stroke-like problems
		19. High blood pressure
		20. High Cholesterol
Y	N	**RESPIRATORY**
		21. Chronic cough or other breathing problems/asthma
		22. Tuberculosis or exposure to tuberculosis
Y	N	**GASTROINTESTINAL**
		23. Stomach or bowel problems
		24. Liver problems (hepatitis or tumor, etc.)
		25. Gallbladder problems
Y	N	**GENITOURINARY**
		26. Bladder or kidney problems
		27. Uterine fibroids
		28. Ovarian cysts
		29. Breast lump or discharge
		30. Vaginal discharge that itches/burns or has a bad odor
		31. Endometriosis
		32. Pain with sex
		33. Previous abnormal pap. When?
		34. Did your mother take DES when she was pregnant with you to prevent a miscarriage?
		35. History of sexually transmitted infection. Check type: ❑chlamydia ❑gonorrhea ❑genital warts ❑herpes ❑syphilis ❑PID
Y	N	**MUSCULOSKELETAL**
		36. Arthritis or osteoporosis
Y	N	**SKIN**
		37. Acne or other skin problems. What?
Y	N	**NEUROLOGICAL**
		38. Migraine headaches (diagnosed by Dr./NP/PA)
		39. Seizures/epilepsy
		40. Numbness in arms/legs (recurring)
Y	N	**PSYCHOLOGICAL**
		41. Depression, requiring treatment
Y	N	**ENDOCRINE**
		42. Thyroid problems
		43. Diabetes

A. REVIEW OF SYSTEMS		
YES	**NO**	**HEMATOLOGICAL/LYMPHATIC**
		44. Anemia
		45. Sickle cell disease/trait
		46. Blood clotting disorder
Y	N	**ALLERGY/IMMUNOLOGY**
		47. Rubella (German measles)
		48. Vaccine for Rubella (German measles)
		49. Tetanus immunization. Date?
		50. Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, what?

B. HOSPITALIZATION AND SURGERIES

Year	Reason

C. FAMILY HISTORY

Are you adopted? ❑ Yes ❑ No

Have your biological family (parents, brothers, sisters) had any of the following?

YES	*NO*	*Diagnosis*	*Relative*
		Osteoporosis	
		Diabetes	
		Heart attack/stroke before age 50	
		High blood cholesterol or fats	
		Genetic problems	
		Cancer	

STAFF COMMENTS / EXPLANATIONS (by number)

PLEASE COMPLETE OTHER SIDE ➡➡➡

Client Name _____

DOB _____ **Age** _____ **MR #** _____

D. PREGNANCY HISTORY ■ never pregnant

DELIVERED					ABORTION / MISCARRIAGE			
Mo.	Yr.	Vag.	C-Sec.	Birth Weight	Year	Weeks	Spont.	Induced

E. CONTRACEPTIVE HISTORY

Current birth control method:

How long used:

Any problems with this method? ☐No ☐ Yes,
If yes, What :

What method do you want to use now?

Are you planning a pregnancy in the NEXT year? ❑ Yes ❑ No

WHICH OF THE FOLLOWING METHODS HAVE YOU USED IN THE PAST:

	METHOD	COMMENTS/PROBLEMS
	Abstinence	
	☐ Tubal ☐ Vasectomy ☐ Hysterectomy	
	Oral Contraceptives (the pill)	
	Norplant	
	Depo-Provera (Injection)	
	Lunelle (injection)	
	IUD: ☐ Paraguard ☐ Mirena	
	Condoms	
	☐ Diaphragm ☐ Cap	
	Sponge	
	☐ Rhythm ☐ NFP	
	Withdrawal	
	Patch (Ortho Evra)	
	Ring (NuvaRing)	

F. SOCIAL HISTORY

MARITAL STATUS:

☐ NEVER MARRIED ☐ MARRIED ☐ WIDOWED ☐ OTHER:

YES	NO	HAVE YOU RECENTLY EXPERIENCED:	COMMENTS
		☐ Emotional ☐ relationship problems	
		Death of ☐ family member ☐ friend	
		☐ Job loss ☐ financial problems	
		Problems in ☐ living arrangements ☐ school	
		☐ Legal problems ☐ arrests ☐ divorce	
		Parental problems	
		Are you physically abused?	
		Has anyone forced you to have sex?	
		Are you sexually abused?	
		Are you afraid of your ☐ partner ☐ family member?	
		Who helps and supports you with problems?	

G. MENSTRUAL HISTORY

1) Age periods began:

2) Number of pads/tampons used on heaviest day:

3) Length of period: (days)

4) Are your periods usually regular? ❑ Yes ❑ No

5) Last period started on: _____
It seemed: ❑ normal ❑ not normal

6) Do you experience, before or with periods: ❑ cramps ❑ bloating ❑ bowel problems ❑ emotional changes

7) Do you have vaginal bleeding after sex? ❑ Yes ❑ No

8) Do you have vaginal bleeding between menstrual periods: ❑ Yes ❑ No

H. STI / HIV RISKS

Number of sex partners in your life: MALE: FEMALE:

How many sex partners have you had during the past year?

YES	NO		COMMENTS
		Have you ever used street drugs? If Yes, when?	
		Have you received blood or blood products since 1978?	
		Was any partner: ☐ a street drug user, ☐ a Hemophiliac, or ☐ infected with HIV / AIDS?	
		Have you shared needles? Example: Injecting drugs, tattooing, piercing?	

COMMENTS

To the best of my knowledge the information I have provided is correct and complete.

Client Signature Date

Clinician Signature Date

Annual Review of Medical History	Date:	Date:
	Clinician Sig:	Clinician Sig:

Client Name _____
DOB _____ **Age** _____ **MR #** _____