

Medical History

Name: _____ Date: _____ Patient #: _____

PPIL serves a wide range of women. We have tried to make this form as complete as possible, realizing that some questions will not apply to every woman's particular circumstances. All information is confidential.

CONTRACEPTIVE HISTORY Please check all birth control methods you have used: Pill Depo Shot
 Patch Nuva Ring IUD/IUS Condoms Sterilization Diaphragm Withdrawal Lunelle
 Sponge Fertility Awareness Implanon Norplant Other _____

<p>Menstrual History</p> <p>Age periods started: _____ How often do you get your period? _____ Period lasts how many days? _____</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your last period abnormal? <input type="checkbox"/> <input type="checkbox"/> Severe cramps? <input type="checkbox"/> <input type="checkbox"/> Missed periods? <input type="checkbox"/> <input type="checkbox"/> Bleeding between periods?</p> <p>Please describe any problems you have with your periods: _____ _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had an abnormal pap?</p> <p>Date of last pap? ____ / ____</p>	<p>Pregnancy History <input type="checkbox"/> Never Pregnant (skip to next section)</p> <p>Age at first pregnancy : _____ Total Pregnancies: _____ Living children: _____</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 20%; text-align: center;">Dates</th> </tr> </thead> <tbody> <tr><td>Abortions</td><td>_____</td></tr> <tr><td>Miscarriage</td><td>_____</td></tr> <tr><td>Still births</td><td>_____</td></tr> <tr><td>Caesarean births</td><td>_____</td></tr> <tr><td>Ectopic Pregnancies (tubal)</td><td>_____</td></tr> <tr><td>Live births</td><td>_____</td></tr> <tr><td>Genetic abnormalities</td><td>_____</td></tr> <tr><td style="padding-left: 20px;">Condition: _____</td><td></td></tr> <tr><td>Gestational diabetes?</td><td>_____</td></tr> </tbody> </table> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Are you breastfeeding now?</p>		Dates	Abortions	_____	Miscarriage	_____	Still births	_____	Caesarean births	_____	Ectopic Pregnancies (tubal)	_____	Live births	_____	Genetic abnormalities	_____	Condition: _____		Gestational diabetes?	_____
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Allergies
 (Please list all allergies, including drug, metal, skin allergies or irritants)

No allergies

Family History I am adopted (skip to next section if you do not know biological family medical history)

Has anyone in your **immediate family** ever had the following? If yes, indicate father(F), mother(M), brother(B), sister(S).

Diabetes _____	Mental Health Problems _____
High Cholesterol _____	Stroke _____
Heart Attack/Surgery _____	High Blood Pressure _____
Cancer of Breast/Uterus/Ovary/Cervix _____	

Did your mother take hormones (DES) while pregnant with you? Yes No Don't Know

Past Medical History

Have you ever had surgery or been hospitalized? Yes No Reason and Dates: _____

Are you now, or have you been, under a doctor's care for a serious illness or condition? Yes No Reason and Dates: _____

List any medications or drugs you are now taking or take often, including over-the-counter medications, herbal medications, and vitamins: _____

Do you have another source of health care? Yes No Where? _____

Sexual History

Age at first intercourse : _____ Is your partner(s) Male Female Both How long have you been with your current partner(s)? _____ How many sexual partners do you have now? _____ In your lifetime? _____

Check type(s) of sex you have: Vaginal Oral Anal Heavy petting Other _____

Do you have any concerns/problems related to abuse, violence, or an assault which you would like to discuss? Yes No

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Personal Medical History Have you had or do you now have any of the following? (please check each item)

1. General

- Yes No
- My health is generally good
- Recent unexplained weight loss or gain
- Cancer
- Genetic Condition

2. Immunizations

- Yes No
- Rubella (German Measles)
- Tetanus Vaccine-shot
- HPV Vaccine
- Hepatitis B

3. Cardiovascular

- Yes No
- Heart disease/murmur
- High Cholesterol
- High Blood Pressure

4. Neurologic

- Yes No
- Stroke
- Migraine
- Seizures/Epilepsy

5. Gastrointestinal

- Yes No
- Stomach/bowel problems
- Liver disease/jaundice
- Hepatitis
- Gall Bladder disease

6. Endocrine

- Yes No
- Diabetes
- Thyroid problems

7. Respiratory

- Yes No
- Asthma

8. Genitourinary

- Yes No
- Frequent bladder infections
- Abnormal Pap smear
- Pelvic Infection/PID
- Sexually transmitted Infection:
Chlamydia, Gonorrhea, Herpes,
Syphilis, Genital Warts, Other

9. Breast

- Yes No
- Breast problems: Discharge, Lump,
Disease, Tumor, Surgery

10. Hematologic

- Yes No
- HIV
- Anemia
- Blood clotting disorder
- Blood transfusion
- Sickle Cell Anemia/Trait
- Rhogam given with prior pregnancy

11. Skin

- Yes No
- Severe Acne
- Tanning

12. Psychologic

- Yes No
- Depression
- Anxiety
- Seeing a therapist

13. Social

- Yes No
- Alcohol Drinks per week _____
- Smoking Packs per week _____ How many years? _____
- Drug Use Type _____

FILL THIS OUT IF YOU ARE UNDER 18 YEARS OF AGE

- Yes No
- Are your parents or guardian aware of your visit to Planned Parenthood?
- If not, did you discuss your plans to come to the health center with another adult? Who? _____
- Would you like information on talking to your parents about sexuality?
- Are you in a relationship where you are being forced to have sexual relations?

TO THE BEST OF MY KNOWLEDGE, ALL OF THE INFORMATION ON THIS FORM IS CORRECT

Patient Signature _____ Date _____
 _____ Date _____
 _____ Date _____

Clinician Signature: _____ Date _____
 _____ Date _____
 _____ Date _____
 _____ Date _____
 _____ Date _____