

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

Female Limited Services History

- Some of these questions are personal, but they help us in evaluating your health.
- If you have answered these questions on a previous visit & there is no change to your health history, please check the "no change" box in that section.

Reason for today's visit: _____		Age: _____	
PAST MEDICAL HISTORY <input type="checkbox"/> No change since last visit		SOCIAL HISTORY <input type="checkbox"/> No change since last visit ♥	
Yes	No	Nicotine, Alcohol, and/or Drug Use	
		Smoke cigarettes, cigars, pipes, or chew tobacco	
		How much per day? _____	
		Drink alcohol (beer, wine, liquor) – _____ drinks per week	
		Do you or your partner use street or IV drugs?	
		Do you feel like you should cut down or stop using alcohol/drugs?	
		Relationship & Safety Violence and sexual abuse are common in many people's lives. There is help for you if you are being hurt or abused. (Note: PPM is required to report cases of child abuse or neglect that occurred as a minor, even if you are now over age 18.)	
		My partner has threatened or frightened me.	
		<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline	
		My partner has physically abused me.	
		<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline	
		I have been forced to have sex.	
		<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline	
HOSPITALIZATIONS / SURGERIES <input type="checkbox"/> No change since last visit		GYN HISTORY	
Year	Reason	_____ What was the first day of your last normal menstrual period? _____ Age periods started Periods come every _____ days and last _____ days. Please describe any problems you have had with your periods: _____	
		Is this your first pelvic (GYN) exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Yes	No
		Do you have any of the following?	
		Breast pain, lump, or discharge	
		Sores or bumps on or in genital area	
		Unusual vaginal discharge	
		Pain with urination	
		Unusual vaginal bleeding	
		Do you protect yourself from pregnancy?	
		If yes, how? _____	
		Date of last sex without a birth control method: _____	
		Previous pregnancies.	
		# pregnancies _____ # children _____	
		Previous ectopic (tubal) or molar pregnancy	
		Do you think you might be pregnant now?	
		Breastfeeding now?	
		Genital trauma/ surgery. Please explain: _____	
		Bleeding or pain during or after sex	
		Do you douche?	
FAMILY PLANNING HISTORY		FILL OUT THIS SECTION IF YOU ARE UNDER 18 YEARS OLD	
Yes	No	Yes	No
		Are your parent(s)/guardian(s) aware of your visit to Planned Parenthood of Maryland?	
		CLIENT SIGNATURE TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.	
		X _____ Date: _____	
		Are you sexually active now? Check all that apply. <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral Date of last sex? _____	
		Have you had a new or more than one sexual partner in the last three months? How long have you been with your current partner? _____ Partners are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	
		Have you ever had a sexually transmitted infection? ♥ If so, please check: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Genital Warts <input type="checkbox"/> Cervical HPV <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Herpes <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomoniasis <input type="checkbox"/> Other _____	
		Has your partner been treated for a sexually transmitted infection? If yes, which one? _____	
		Do you have any other questions or concerns about sex that you would like to discuss today? Explain: _____	

♥ = **Babies Born Healthy:** These health issues are important for having a healthy baby as well as maintaining your own health.

