

PLACE PT LABEL HERE

FEMALE MEDICAL HISTORY / REVIEW OF SYSTEMS

Name: _____

Date: / /

Age: _____

PERSONAL HISTORY		YES	NO	CARDIOVASCULAR – Do you have or have you ever had:		YES	NO
1. Are you being treated for any illness/condition now?		<input type="checkbox"/>	<input type="checkbox"/>	1. Swollen feet/legs?		<input type="checkbox"/>	<input type="checkbox"/>
If yes, what?				2. Varicose veins/phlebitis?		<input type="checkbox"/>	<input type="checkbox"/>
2. Do you smoke cigarettes?		<input type="checkbox"/>	<input type="checkbox"/>	3. High blood pressure?		<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many per day?				4. High cholesterol or fats?		<input type="checkbox"/>	<input type="checkbox"/>
3. Do you drink alcohol?		<input type="checkbox"/>	<input type="checkbox"/>	5. Heart disease, heart surgery, or heart murmur?		<input type="checkbox"/>	<input type="checkbox"/>
If yes, how often?				6. Stroke or stroke-like symptoms?		<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use street drugs?		<input type="checkbox"/>	<input type="checkbox"/>	STAFF COMMENTS:			
If yes, what?							
5. Do you use over-the-counter drugs?		<input type="checkbox"/>	<input type="checkbox"/>				
If yes, what?				GASTROINTESTINAL – Do you have or have you ever had:		YES	NO
6. Do you take prescription drugs?		<input type="checkbox"/>	<input type="checkbox"/>	1. Frequent nausea/vomiting?		<input type="checkbox"/>	<input type="checkbox"/>
If yes, what?				2. Diarrhea on a regular basis?		<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel safe in your current relationship?		<input type="checkbox"/>	<input type="checkbox"/>	3. Blood in your stool?		<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have concerns about domestic violence?		<input type="checkbox"/>	<input type="checkbox"/>	4. Stomach problems, bowel problems, or ulcers?		<input type="checkbox"/>	<input type="checkbox"/>
9. Is anyone forcing you to have sex?		<input type="checkbox"/>	<input type="checkbox"/>	5. Severe heartburn?		<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:				STAFF COMMENTS:			
PREGNANCY HISTORY		YES	NO	MUSCULOSKELETAL		YES	NO
1. How many times have you been pregnant?				1. Do you ever have swollen/painful joints?		<input type="checkbox"/>	<input type="checkbox"/>
2. Number of live births:	3. Number of living children:			2. How many times have you broken a bone?			
4. Age of each child:	5. Number of premature:			3. Do you have any sensory difficulties?		<input type="checkbox"/>	<input type="checkbox"/>
6. Number of c-sections:	7. Number with birth defects:			STAFF COMMENTS:			
8. Number of fetal death:	9. Number of abortions:						
10. Number of miscarriages:	11. Number of ectopic:			NEUROLOGICAL – Do you have or have you ever had:		YES	NO
12. Number of vaginal deliveries:				1. Migraines/severe headaches diagnosed by a Dr.?		<input type="checkbox"/>	<input type="checkbox"/>
13. Are you breast-feeding now?		<input type="checkbox"/>	<input type="checkbox"/>	2. Visual changes not related glasses or contacts?		<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have plans for pregnancy in the next year?		<input type="checkbox"/>	<input type="checkbox"/>	3. Fainting when your blood is drawn?		<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:				4. Seizure disorder/epilepsy?		<input type="checkbox"/>	<input type="checkbox"/>
				STAFF COMMENTS:			
MENSTRUAL HISTORY		YES	NO	ENDOCRINE		YES	NO
1. What was the first day of last menstrual period? Date: / /				1. Are you frequently thirsty for no reason?		<input type="checkbox"/>	<input type="checkbox"/>
2. Was this a normal period?		<input type="checkbox"/>	<input type="checkbox"/>	2. Do you have swelling in your neck?		<input type="checkbox"/>	<input type="checkbox"/>
3. Are your periods usually regular?		<input type="checkbox"/>	<input type="checkbox"/>	3. Do you have night sweats/ hot flashes?		<input type="checkbox"/>	<input type="checkbox"/>
4. How many days does your bleeding usually last?				4. Do you have diabetes/gestational diabetes?		<input type="checkbox"/>	<input type="checkbox"/>
5. How many days are your cycles?				5. Do you have thyroid disease?		<input type="checkbox"/>	<input type="checkbox"/>
6. Is your period usually: () light () medium () heavy				STAFF COMMENTS:			
7. At what age did your period begin?							
8. Do you have the following with your periods (check ✓ all that apply):				ALLERGY / IMMUNOLOGY		YES	NO
() cramps () nausea () headaches () back aches				1. Do you have any allergies?		<input type="checkbox"/>	<input type="checkbox"/>
() pre-menstrual tension () bleeding/spotting in between periods				2. Are you up to date with your rubella vaccination?		<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:				STAFF COMMENTS:			

FEMALE MEDICAL HISTORY / REVIEW OF SYSTEMS

SEXUAL HISTORY	YES	NO
1. Are you currently sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
2. When was the last time you had sex?		
3. Could you be pregnant now?	<input type="checkbox"/>	<input type="checkbox"/>
4. How many sexual partners do you currently have?		
5. How long have you been with your current partner(s):		
6. How many partners have you had in the past 12 months?		
7. Do you have sex with: <input type="checkbox"/> men <input type="checkbox"/> women <input type="checkbox"/> both		
8. Do you participate in (check <input checked="" type="checkbox"/> all that apply): <input type="checkbox"/> oral sex <input type="checkbox"/> vaginal sex <input type="checkbox"/> anal sex <input type="checkbox"/> outer course		
9. At what age did you first start having sex?		
10. Do you have sexual concerns?	<input type="checkbox"/>	<input type="checkbox"/>

STAFF COMMENTS:

FAMILY HISTORY	MOTHER	FATHER	BROTHER	SISTER
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Family history not available
 Has your biological family had any of the following (check all that apply):

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke before age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease before 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol or fats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer	<input type="checkbox"/>			<input type="checkbox"/>

STAFF COMMENTS:

BIRTH CONTROL	YES	NO
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1. Are you currently using a birth control method? YES NO
 If yes, what?

2. What birth control method do you desire?

3. If you have ever used birth control in the past, please list:

Type of birth control	When used	Problems, if any

STAFF COMMENTS:

GENITOURINARY	YES	NO
1. Have you had urinary tract, bladder, kidney infections or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have pain or bleeding with sex?	<input type="checkbox"/>	<input type="checkbox"/>

When was your last Pap smear? Date: / /

3. Have you ever had an abnormal Pap smear? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, when?		
4. Have you had any of the following (check <input checked="" type="checkbox"/> all that apply): <input type="checkbox"/> colposcopy <input type="checkbox"/> cryosurgery <input type="checkbox"/> laser <input type="checkbox"/> LEEP <input type="checkbox"/> endometriosis <input type="checkbox"/> fibroids <input type="checkbox"/> ovarian cysts		

5. Have you had any of the following (check <input checked="" type="checkbox"/> all that apply): <input type="checkbox"/> chlamydia <input type="checkbox"/> gonorrhea <input type="checkbox"/> genital warts <input type="checkbox"/> herpes <input type="checkbox"/> syphilis <input type="checkbox"/> PID <input type="checkbox"/> HIV		
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6. Did your mother take DES when she was pregnant with you? <input type="checkbox"/> YES <input type="checkbox"/> NO		
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STAFF COMMENTS:

HEMATOLOGICAL / LYMPHATIC	YES	NO
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1. Have you ever had a breast lump or discharge from your nipples? <input type="checkbox"/> YES <input type="checkbox"/> NO		
2. Do you have swollen glands under your arms? <input type="checkbox"/> YES <input type="checkbox"/> NO		
3. If you get cut, do you bleed excessively? <input type="checkbox"/> YES <input type="checkbox"/> NO		
4. Do you have frequent bruising for no reason? <input type="checkbox"/> YES <input type="checkbox"/> NO		
5. Have you ever been anemic? <input type="checkbox"/> YES <input type="checkbox"/> NO		
6. Do you have a blood clotting disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO		
7. Have you ever had breast surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO		
8. Do you have a history of cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STAFF COMMENTS:

RESPIRATORY	YES	NO
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1. Do you have lung disease (asthma, TB)? <input type="checkbox"/> YES <input type="checkbox"/> NO		
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STAFF COMMENTS:

PSYCHOLOGICAL	YES	NO
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1. Do you have depression, mental illness, or anxiety disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO		
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STAFF COMMENTS:

I give the above information freely. It is complete and correct to the best of my knowledge. I understand that it is for Planned Parenthood's use only and will not be released to anyone else without my written permission unless ordered to do so by court order.

Patient Signature: _____

Date: _____

Medical Provider Signature: _____

Date: _____