

Planned Parenthood® Bucks County ANNUAL UPDATE - FEMALE <input type="checkbox"/> Bristol <input type="checkbox"/> Bensalem <input type="checkbox"/> Doylestown <input type="checkbox"/> Quakertown <input type="checkbox"/> Warminster <input type="checkbox"/> DVC <input type="checkbox"/> Foundations	Patient Name _____ Account # _____ Date of Birth _____
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Date _____ Age _____ Family doctor/source of medical care _____

Reason for visit _____

Allergies (medications, metals, latex, or anesthesia): _____

Current Medications (include herbs/vitamins/metals): _____

FAMILY HISTORY UPDATE

In the last year, List **ONLY** blood-related parents, brothers and sisters who have had a serious illness including diabetes, heart disease, high blood pressure, breast disease, and cancer?

List _____

PERSONAL HISTORY UPDATE

Day your most recent period began: ____/____/____ Was this period normal? (circle) **YES** **NO**

Yes No *In the LAST YEAR, have you had any of the following* (Please check)

- A Serious illness, injury, surgery or hospitalization? _____
- A Breast Problem (including lump, discharge, surgery, etc)? _____
- A Sexually Transmitted Infection (chlamydia, gonorrhea, syphilis, herpes, HPV, etc)? _____
- A problem with your uterus, tubes or ovaries? _____
- Any problems with your periods (like missed periods or bleeding between periods)? _____
- A Pregnancy? Date _____ Outcome _____
- A new sex partner or more than one sex partner? How long with current partner(s)? _____

Yes No

- Are you planning a pregnancy in the next year?
- Are you currently using a birth control method? If yes, what method? _____
- Do you have questions about or problems with your method? If yes, what? _____

What Birth control method are you interested in today, if any? _____

CURRENT REVIEW OF SYSTEMS:

Yes No *Please check any of these symptoms you have experienced RECENTLY.*

- General:** Recent weight change/ Fever/ Night sweats/ Hot flashes
- Ears, Nose, Throat, Mouth:** Nosebleeds/ Mouth sores or ulcers
- Neurological:** Headaches/ Seizures/ Dizziness
- Psych:** Anxiety/ Severe depression/ Mood changes/ Eating disorder
- Cardiovascular:** Heart Palpitations/ Chest pain/ Swelling in hands/feet
- Musculoskeletal:** Broken bones/ Arm or leg pain or weakness
- Gastrointestinal:** Yellowing of skin or eyes/ Rectal pain or bleeding

Yes No

- Eyes:** Blurred or double vision
- Endocrine:** Increase in body hair/Loss of scalp hair
- Skin:** Skin Rash/ Change in mole/ Acne
- Respiratory:** Persistent cough/Breathing problems
- Hematological:** Lymph node enlargement
- Genitourinary:** Pain when urinating/Difficult to hold urine/ Abnormal vaginal discharge/itch/Pain or bleeding with sex

SOCIAL HISTORY

Yes No

- Smoke: # _____ cigarette(s) per day
- Alcohol: # _____ drinks per day/week
- Street Drugs: _____

Yes No

- Have you ever been a victim of sexual abuse or coercion?
- Have you been hit, hurt or made to feel afraid by an intimate partner, now or in the past?

I acknowledge that the above is correct & complete. If any reportable disease is found, it will be reported to the Health Department.

Patient Signature _____ Date _____

- Teen counseling provided (if < age 18). Parental Involvement _____
- STI/Safer Sex/condom use discussed
- Prophylactic ECPs discussed/ requested/ refused (940)

Staff Signature _____ Title _____

Above Health History reviewed by: (Clinician signature) _____ Date _____
 (Clinician signature) _____ Date _____