

PLANNED PARENTHOOD OF IDAHO

Name: _____ Date of Birth: _____ Age: _____

Today's Date: _____ Patient #: _____

Reason for today's visit? _____

Family History: In the past year have there been any changes in your family's health, including breast disease, cancer, diabetes, high blood pressure or heart disease? YES NO Unsure

If "YES," please list: _____

PERSONAL HISTORY: in the last year have you had:

Hospitalization	YES-	NO	New Allergies	YES-	NO
Diabetes	YES-	NO	Headaches/Visual Changes	YES-	NO
Depression	YES-	NO	High Blood Pressure	YES-	NO

Any new problems in the last year with your:

Liver	YES-	NO	Stomach/ Bowel	YES-	NO
Breasts	YES-	NO	Bladder/ Kidneys	YES-	NO
Heart/ Lungs	YES-	NO	Uterus, Tubes, Ovaries	YES-	NO

Do you smoke? **YES / NO.** Amount per day: _____ Do you drink? **YES/ NO.** Amount per day: _____

Are you taking any medications? YES NO If "YES," please list: _____

Are you allergic to any medications? YES NO If "YES," please list: _____

Any serious medical problems in the last year? YES NO If "YES," please list: _____

Would you like to discuss problems related to rape or emotional/ physical /sexual abuse? YES NO

*Does anyone hit, slap, kick, hurt you or force you to have sex? YES NO

*Are you afraid of your partner(s) or other? YES NO

*If you are under 18 and answered yes to above questions, we are required to report abuse to the proper authorities.

MENSTRUAL/ SEXUAL/ PREGNANCY/ CONTRACEPTIVE HISTORY:

The first day of your last menstrual period was: _____. Was this period abnormal? YES NO If "YES," how was it abnormal? _____

Have you ever been pregnant? If YES, how many: Births: _____ Abortions: _____ Miscarriages: _____		
Are you planning a pregnancy in the next year?	NO	Yes-
In the past 2 days have you: <input type="checkbox"/> Used Douches? <input type="checkbox"/> Used Tampons? <input type="checkbox"/> Had sex? <input type="checkbox"/> Had any bleeding?	NO	Yes-
Are you currently experiencing any: <input type="checkbox"/> vaginal itching <input type="checkbox"/> burning <input type="checkbox"/> abnormal odor <input type="checkbox"/> discharge	NO	Yes-
Are you currently having any burning with urination or an increased frequency and urgency to urinate?	NO	Yes-
Are you currently having any bleeding or pain with sex?	NO	Yes-
Have you been treated for a sexually transmitted infection somewhere else in the last year?	NO	Yes-
Would you like information on safer sex practices?	NO	Yes-
Do you have any questions about birth control?	NO	Yes-

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Patient Name: _____ Patient # : _____

What is your current birth control method?

- None Pill Depo Provera Condoms IUD
 Diaphragm Abstinence Withdrawal Rhythm/Natural Spermicide Implanon

Number of partners in the last year? _____. Do you use condoms Yes No Sometimes

How long have you been with your current partner? _____

Clinician Notes:

Clinician Signature: _____ Date: _____