

Female Self-Medical History

Today's date _____

Name _____ Age _____ Occupation _____

Reason for today's visit: _____ I'd like to be tested for STIs _____

Menses	Sexual History
<p>When was the first day of your last menstrual period? _____ How many days does it usually last? _____ How old were you when your periods started? _____</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your last menstrual period normal?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have a period every month?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you concerned that you could be pregnant?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have severe cramps with your periods?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you bleed between periods?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you douche? If yes, how often? _____</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had sexual intercourse? Age at first time: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you currently in a sexual relationship? Duration of current relationship: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> New sex partner in last 60 days?</p> <p><input type="checkbox"/> <input type="checkbox"/> Partner with symptoms in the last 60 days?</p> <p><input type="checkbox"/> <input type="checkbox"/> Positive chlamydia in the last 12 months?</p> <p><input type="checkbox"/> <input type="checkbox"/> Other STI in the last 12 months?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you use a condom with your last intercourse?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had anal or oral sex in the last 12 months?</p> <p>Are your partner(s) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both</p> <p>Any partner(s) with a history of <input type="checkbox"/> Sex with other men</p> <p><input type="checkbox"/> Drug use <input type="checkbox"/> More than 4 partners in the last year?</p> <p>How many sexual partners have you had: In the past year? _____ In your lifetime? _____</p> <p>How do you protect yourself from STIs? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you ever been tested for HIV? If yes, when? _____</p>
Contraception	Social History
<p>Is this your first pelvic exam ever? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>What birth control, including condoms or fertility awareness method, have you used in the past? _____</p> <p>Any problems with them? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what problem? _____</p> <p>Current form of birth control _____</p> <p>How long? _____ Any problems with it? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what _____</p> <p>EC (Plan B): How many times used in the last 12 months? _____</p> <p>Number of Plan B pkgs at home ___ Exp. date if known _____</p> <p>Do you want to change your birth control? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, to which method? _____</p> <p>Do you want children in the future? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> maybe</p> <p>Have you had intercourse without using birth control since your last period? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you smoke? If so, how many cigarettes/day and for how long? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you drink alcohol? If so, how often/how much? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you or your partner use street or IV drugs? If so, what _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you exercise regularly?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have concerns about your weight or eating habits that you would like to discuss today?</p> <p>Planned Parenthood can help women and men who have concerns about sexuality, or have had a history of sexual assault, rape (including date-rape), physical abuse, domestic violence (including between unmarried partners as well as same-sex partners), addictions, or emotional/mental health difficulties. We can also help if you are currently in a situation where any of these are occurring, have recently occurred, or are of immediate concern to you.</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you now experiencing or have concerns about domestic violence or any of the above-mentioned issues?</p> <p>For Clinicians Only:</p> <p><input type="checkbox"/> <input type="checkbox"/> Client was queried about all the above</p> <p><input type="checkbox"/> <input type="checkbox"/> Client was given relevant educational materials and referral information.</p>
Pregnancy	
<p><input type="checkbox"/> Never been pregnant (skip to the next section)</p> <p>Age at first pregnancy _____</p> <p>Last pregnancy _____ # of pregnancies _____</p> <p># Live births _____ # Abortions _____</p> <p># Miscarriages _____</p> <p># Ectopic (tubal) pregnancies _____</p> <p># Living children _____</p> <p>Are you breastfeeding now? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Are you currently trying to become pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Are you concerned about infertility? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	

Place client label here
Include name, number and DOB

Clinician Reviews:

Signature: _____ Date: ___/___/___
 Signature: _____ Date: ___/___/___
 Signature: _____ Date: ___/___/___

Past Medical History

ALLERGIES TO MEDICATION (Please list) _____

Do you have a latex allergy? yes no Other allergies (shellfish, etc) _____

Have you ever had surgery, been a patient in a hospital or had a major illness? yes no

If yes, explain _____

Have you ever had a blood transfusion? _____

List all medications you take: _____

Where else do you go for healthcare? _____

When and where was your last: Pap test? _____ **Mammogram?** _____

Have you had the following immunizations:

Hep B series yes no Tetanus yes no Rubella yes no Gardasil yes no

Please review the following list. Let us know your past health history and what symptoms you have TODAY: (Review of Systems)

Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/> Never <input type="checkbox"/>
<p>GENERAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> My health is generally good</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recent 25+ lb. weight gain or loss</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night sweats/hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever, chills</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p>SKIN</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rash, bumps, sores</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other skin problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Acne</p> <p>EYES</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visual changes (except contacts / glasses)</p> <p>EARS, NOSE, THROAT</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hearing problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent nosebleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent sore throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal polyps</p> <p>ENDOCRINE</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes of pregnancy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid problems</p> <p>NEUROLOGIC</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Persistent numbness, tingling</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diagnosed migraines</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy/seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stroke</p>	<p>CARDIOVASCULAR</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Palpitations / heart murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood clots in veins or lungs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia or bleeding disorder</p> <p>BREASTS</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mass or lump</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Discharge, tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breast surgery</p> <p>RESPIRATORY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breathing problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p>GASTROINTESTINAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irritable bowel syndrome</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gall bladder disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver disease / Hepatitis Type _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach ulcer</p> <p>MUSCULOSKELETAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Joint or muscle pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spontaneous fractures</p>	<p>GENITOURINARY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge, odor, itch</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Genital rash, bumps, sores</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bleeding after intercourse</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain with intercourse</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain or burning with urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloody urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Urine leaking / incontinence</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent bladder infections</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Endometriosis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ovarian cysts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Uterine fibroids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Genital warts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PID (Pelvic Inflammatory Disease)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trichomoniasis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent yeast infections</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bacterial vaginosis (BV)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal Pap smear</p> <p>Date of abnormal _____</p> <p>Treatment _____</p> <p>Date of treatment _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colposcopy</p> <p>PSYCHOLOGICAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anxiety/mood swings</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Under psychiatric care</p>

IMMEDIATE FAMILY HISTORY: Have your mother, father, sister, or brother had the following before age 55? Please check each item

Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are you adopted?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breast or ovarian cancer? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart attack/stroke/blood clots? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TB (Tuberculosis)? _____</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High cholesterol? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Osteoporosis (brittle bones)? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> History of inheritable disease? _____ (Tay-Sachs, sickle cell anemia, etc.)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Was your mother given DES? _____ (to prevent miscarriages)</p>

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Patient Signature _____