



Planned Parenthood® of Santa Barbara, Ventura and San Luis Obispo Counties, Inc.

FEMALE MEDICAL HISTORY

Your records are considered confidential. Planned Parenthood will call or write only if we need to contact you regarding test results that are not normal, or for emergency purposes.

Patient Name: _____
AGE _____ ALLERGIES _____ DATE COMPLETED _____

REVIEW OF SYSTEMS

HAVE YOU EVER HAD:

GENERAL

- YES NO**
 Eating disorder
 Frequent colds/flu, etc.
 Chronic fatigue
 Cancer
 My health is good

SKIN

- YES NO**
 Acne/other skin problems
 Chronic rash, itching

EYES

- YES NO**
 Eye problems/visual problems
 Do you wear glasses/contacts?

EARS, NOSE, THROAT, MOUTH

- YES NO**
 Hearing problems
 Teeth/gum problems
 Frequent nosebleeds
 Frequent sore throats

RESPIRATORY

- YES NO**
 Asthma/Lung disease/TB
 Persistent shortness of breath

CARDIOVASCULAR

- YES NO**
 Heart disease/Murmur/Stroke
 High blood pressure
 High cholesterol/Triglycerides
 Thrombophlebitis/Blood clots in veins/lungs
 Lupus Erythematosus

GASTROINTESTINAL

- YES NO**
 Stomach/Bowel problems
 Liver disease/Hepatitis
 Gall bladder disease

GENITOURINARY

- YES NO**
 Bladder/kidney problems
 Problems of infection with uterus/tubes/ ovaries
 Recurrent vaginal infection
 Chlamydia
 Gonorrhoea
 Herpes
 Syphilis
 Genital Warts
 HIV
 Other
 Breast disease/Lump/Tumor/Surgery
 Abnormal Pap Smear

NEUROLOGIC

- YES NO**
 Stroke
 Migraine (diagnosis by MD)
 Seizures/Epilepsy
 Numbness

HEMATOLOGIC

- YES NO**
 Anemia
 Blood disorder/transfusion

MUSCULOSKELETAL

- YES NO**
 Arthritis
 Broken Bones/Fractures

PSYCHOLOGY

- YES NO**
 Depression/Mood Swings
 Anxiety
 Under care of Psychiatrist/Psychologist

ENDOCRINE

- YES NO**
 Thyroid disease
 Diabetes
 Persistent swollen glands

PAST MEDICAL HISTORY:

Have you ever had surgery or been a patient in a hospital? YES explain _____ NO

Are you now, or have you been, under a doctor's care for a serious illness or condition? YES NO

Do you have a personal physician? YES NO If yes, Name and Contact Number: _____

Do you have any drug allergies? YES NO If yes, what? _____
 Local anesthesia? YES NO Are you allergic to latex? YES NO Betadine? YES NO

Have you had childhood immunizations? YES NO

Have you been immunized for Hepatitis B? YES NO

Please list any drugs you are taking now, including over-the-counter medications, herbal medications, and vitamins. _____

Date of last pelvic exam _____

PATIENT LABEL

