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 LABEL

AGE __________ ALLERGIES ____ DATE COMPLETED ________________

REVIEW OF SYSTEMS **HAVE YOU EVER HAD:**

GENERAL

	YES	NO	
1.	☐	☐	Eating disorder
2.	☐	☐	Frequent colds/flu, etc.
3.	☐	☐	Chronic fatigue
4.	☐	☐	Cancer
5.	☐	☐	My health is good

SKIN

	YES	NO	
6.	☐	☐	Acne/other skin problems
7.	☐	☐	Chronic rash, itching

EYES

	YES	NO	
8.	☐	☐	Eye problems/visual problems
9.	☐	☐	Do you wear glasses/contacts?

EARS, NOSE, THROAT, MOUTH

	YES	NO	
10.	☐	☐	Hearing problems
11.	☐	☐	Teeth/gum problems
12.	☐	☐	Frequent nosebleeds
13.	☐	☐	Frequent sore throats

RESPIRATORY

	YES	NO	
14.	☐	☐	Asthma/Lung disease/TB
15.	☐	☐	Persistent shortness of breath

CARDIOVASCULAR

	YES	NO	
16.	☐	☐	Heart disease/Murmur/Stroke
17.	☐	☐	High blood pressure
18.	☐	☐	High cholesterol/Triglycerides
19.	☐	☐	Thrombophlebitis/Blood clots in veins/lungs
20.	☐	☐	Lupus Erythematosis

GASTROINTESTINAL

	YES	NO	
21.	☐	☐	Stomach/Bowel problems
22.	☐	☐	Liver disease/Hepatitis
23.	☐	☐	Gall bladder disease

GENITOURINARY

	YES	NO	
24.	☐	☐	Bladder/kidney problems
25.	☐	☐	Problems of infection with uterus/ tubes/ ovaries
26.	☐	☐	Recurrent vaginal infection
27.	☐	☐	Chlamydia
	☐	☐	Gonorrhea
	☐	☐	Herpes
	☐	☐	Syphilis
	☐	☐	Genital Warts
	☐	☐	HIV
	☐	☐	Other
28.	☐	☐	Breast disease/Lump/Tumor/Surgery
29.	☐	☐	Abnormal Pap Smear

NEUROLOGIC

	YES	NO	
30.	☐	☐	Stroke
31.	☐	☐	Migraine (diagnosis by MD)
32.	☐	☐	Seizures/Epilepsy

HEMATOLOGIC

	YES	NO	
33.	☐	☐	Anemia
34.	☐	☐	Blood disorder/transfusion

MUSCULOSKELETAL

	YES	NO	
35.	☐	☐	Arthritis
36.	☐	☐	Broken Bones/Fractures

PSYCHOLOGY

	YES	NO	
37.	☐	☐	Depression/Mood Swings
38.	☐	☐	Anxiety
39.	☐	☐	Under care of Psychiatrist/ Psychologist

ENDOCRINE

	YES	NO	
40.	☐	☐	Thyroid disease
41.	☐	☐	Diabetes
42.	☐	☐	Persistent swollen glands

PAST MEDICAL HISTORY:

43. Have you ever had surgery or been a patient in a hospital? ☐ **YES explain** ____________________________________ ☐ **NO**
44. Are you now, or have you been, under a doctor's care for a serious illness or condition? ☐ **YES** ☐ **NO**
45. 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**
45. Have you had childhood immunizations? ☐ **YES** ☐ **NO**
46. Have you been immunized for Hepatitis B? ☐ **YES** ☐ **NO**
47. Please list any drugs you are taking now, including over-the-counter medications, herbal medications, and vitamins. _____________________
    ____
48. Date of last pelvic exam ____________

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I-10 4/05 white

FAMILY HISTORY:

YES	NO	
☐	☐	Diabetes Insulin dependent? ☐ YES ☐ NO
☐	☐	Cancer, especially breast, kidney, ovarian or colon
☐	☐	High levels of cholesterol or fat in blood
☐	☐	Heart attack, stroke, or blood clots
☐	☐	Broken bones after age 35, or osteoporosis
☐	☐	Adopted, unknown family history
☐	☐	Did your mother take DES during her pregnancy with you?

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SOCIAL/SEXUAL RISK HISTORY

YES	NO	
☐	☐	Do you smoke? If yes, how many cigarettes a day?________
☐	☐	Do you use alcohol? If yes, how often/how much?
☐	☐	Do you or your partners use street or IV (injectable) drugs?
☐	☐	Do you or your partners share needles of any kind?
☐	☐	Have you ever had or would you like help now with an alcohol or drug abuse problem?
☐	☐	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
☐	☐	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

Your answers to the following questions will help us assess your risk for cervical cancer and sexually transmitted infections (STIs).

Age at first intercourse: _________

YES	NO	
☐	☐	Are you sexually active now? Check all that apply: ☐ Vaginal ☐ Anal ☐ Oral ☐ Other
☐	☐	Have you had more than one or a new sexual partner in the past year? Are your partners: ☐ Male ☐ Female ☐ Both
☐	☐	Do you take precautions against sexually transmitted infections?
☐	☐	Do you feel that any of your partners have put you at risk for sexually transmitted infections or HIV?
☐	☐	Do you have any other questions or concerns about sex that you would like to discuss during this visit?

REPRODUCTIVE HISTORY

Age at first menstrual period:_______________

YES	NO	
☐	☐	Heavy periods / cramps
☐	☐	Bleeding between periods
☐	☐	Was you last menstrual period normal?

HAVE YOU EVER HAD:

YES	NO	
☐	☐	Bleeding after intercourse
☐	☐	Pain with intercourse

DO YOU CURRENTLY HAVE:

YES	NO	
☐	☐	Lower abdominal pain
☐	☐	Abnormal vaginal discharge

☐ N/A

IF YOU HAVE EVER BEEN PREGNANT, PLEASE ANSWER THE FOLLOWING QUESTIONS

____ Age at first pregnancy
____ Total number of pregnancies
____ Number of live births
____ Number of miscarriages
____ Number of abortions
____ Number of ectopic pregnancies
____ Number of still births
____ Number of living children
____ Number of cesarean births (C-sections)
____ Date of last delivery
____ Date of last abortion

Did you have any complications during your pregnancies? ☐ **YES** ☐ **NO** Any children with genetic disorders (birth defects)? ☐ **YES** ☐ **NO**

Are you Currently Breastfeeding? . **YES** . **NO**

CONTRACEPTIVE HISTORY

Check all birth control methods you have used: ☐ Pill ☐ DEPO ☐ Norplant ☐ IUD ☐ Condoms ☐ Sterilization ☐ Diaphragm ☐ Sponge ☐ Foam/Suppository/Film ☐ Natural Family Planning (Rhythm) ☐ Withdrawal ☐ Other: ______________________

YES	NO	☐ N/A
☐	☐	Do you or your partner use birth control now? If yes, what method(s) do you use? ______________________ How long have you used this method? ______________________
☐	☐	Have you had problems with this or any birth control method?
☐	☐	Do you plan to get pregnant in the next year?
☐	☐	Do you want a birth control method today? If yes, what method? ______________________

IF YOU ARE UNDER 18 YEARS OF AGE:

Are your parents aware of your visit to Planned Parenthood? ☐ YES ☐ NO
Do you talk to your parents about sexuality issues? ☐ YES ☐ NO

To the best of my knowledge this information is complete and correct.

______________________ ______________________

PATIENT SIGNATURE DATE CLINICIAN/RN SIGNATURE DATE

ANNUAL REVIEW #1

☐ No Change ☐ Change (see physical exam notes) ☐ Address Change

Clinician/RN Signature ______________________ Date ______________

ANNUAL REVIEW #2

☐ No Change ☐ Change (see physical exam notes) ☐ Address Change

Clinician/RN Signature ______________________ Date ______________