

Planned Parenthood proudly serves people of all ages, gender identities, national origins, races, and sexual orientations

Legal Name: _____

Preferred Name: _____

Gender: Woman Man Other: _____

Pronoun: He She Other: _____

ALLERGY HISTORY		List/Comments:
Y	N	
		Medications
		Food
		Latex
		Metals
		Anesthesia
		Other:

PERSONAL HEALTH HISTORY (continued)		
Y	N	Comments:
GASTROINTESTINAL		
		Stomach or bowel problems
		Gall bladder disease / stones
		Liver (Hepatitis, Mono, Jaundice)
CARDIOVASCULAR		
		High blood pressure
		High cholesterol
		Heart Disease / Murmur
		Varicose Veins
		Blood Clots/Stroke

IMMUNIZATIONS Have you been vaccinated against the following?	
<input checked="" type="checkbox"/>	Vaccinated for Hepatitis A? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Series completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input checked="" type="checkbox"/>	Vaccinated for Hepatitis B? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Series completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input checked="" type="checkbox"/>	Vaccinated for HPV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Series completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input checked="" type="checkbox"/>	MMR(Rubella) Vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input checked="" type="checkbox"/>	Other? Please specify:

GENITOURINARY		
		Bladder / kidney problems
		Leaking of urine
		Frequent bladder infections
		Recurrent vaginal infections
		Pelvic inflammatory disease
		Uterine problem
		Uterine fibroids
		Ovarian cysts
		Endometriosis
		Abnormal pap smear(s) When?
		Colposcopy / LEEP / cryotherapy
		Did your mother take DES when she was pregnant with you?

MEDICATION HISTORY	
List all current medications including birth control, herbal, and vitamins	

MUSCULOSKELETAL		
		Broken bones / fractures
		Arthritis or Osteoporosis

FAMILY HISTORY		
Y	N	
		Adopted
		History Unknown

SKIN		
		Acne; other problems (specify)
NEUROLOGICAL		
		Headaches / migraines: How often? with visual changes with numbness, tingling, weakness of arms / legs
		Seizures / Epilepsy
		See flashing / sparking lights with or without a headache?

Has your biological mother, father, sister, brother, grandmother, or grandfather had any of the following?		
Y	N	Who?
		Birth defect(s)
		Blood Clots
		Cancer (specify)
		Diabetes
		Heart attack or stroke before age 50
		High Blood Pressure
		High Cholesterol
		Osteoporosis
		Thyroid Disorder
		Other (specify):

PSYCHOLOGICAL		
		Depression / Anxiety / Mood swings
		Eating disorder (Anorexia / Bulimia)
		Other

PERSONAL HEALTH HISTORY		
Do you have or have you ever had any of the following?		
Y	N	Comments:
		Birth defects / genetic conditions
		Cancer, specify site
		Descendant of Ashkenazi Jew
		Breast lump, Nipple discharge

HEMATOLOGICAL/LYMPHATIC		
		Anemia
		Sickle cell disease / trait
		Blood clotting disorder
		Blood transfusion
		Frequent nose bleeds

EYES/EARS		
		Contact Lenses
		Eye glasses
		Hearing Problem

ENDOCRINE		
		Thyroid problems
		Diabetes

RESPIRATORY		
		Asthma / Breathing Problems
		Chronic cough / Tuberculosis

HOSPITALIZATIONS/SURGERY		
		Hospitalizations other than childbirth or emergency room
		Surgeries:

Please continue to back of form ➔

Name: _____

Chart #: _____ DOB: _____

Date: _____
CONFIDENTIAL HEALTH HISTORY

