Planned Parenthood®
Southeastern Pennsylvania

MEDICAL HISTORY - FEMALE

Patient Name:____________________ **Age:**______ **Medical Record #:**____________ **Date:**____________

☐ **New Patient** ☐ **Established Patient**

SUBJECTIVE:

CHIEF COMPLAINT / Why are you here today? ☐ Routine GYN Exam ☐ Problem ☐ Other ____________

No	Yes	
☐	☐	Are you receiving medical care with another health provider? Reason for visit(s) ____________
☐	☐	Are you allergic to any medications, metals, foods, anesthesia or other products? List: ____________
☐	☐	Are you currently taking medications (including herbal remedies and vitamins)? List: ____________

FAMILY HISTORY

No	Yes	
☐	☐	I am adopted; my birth history is unknown.
☐	☐	Did your mother take DES while she was pregnant with you? (if you were born before 1971)

Does your Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM) or Grandfather (GF) have any of the following?

No	Yes		Who	No	Yes		Who
☐	☐	High cholesterol	________	☐	☐	Diabetes	________
☐	☐	High blood pressure	________	☐	☐	Breast disease	________
☐	☐	Heart attack before age 50	________	☐	☐	Cancer	________
☐	☐	Stroke / Blood clots	________	☐	☐	Genetic disorder(s)	________

Circle: Father is living / deceased. Cause of death __________ Mother is living / deceased. Cause of death __________

PERSONAL HISTORY – Have **YOU** been diagnosed or treated for any of the following:

	No	Yes	
1.	☐	☐	Cancer
2.	☐	☐	Genetic condition
3.	☐	☐	High cholesterol / triglycerides
4.	☐	☐	High blood pressure
5.	☐	☐	Heart disease / Murmur / MVP
6.	☐	☐	Stroke / Blood clots
7.	☐	☐	Anemia
8.	☐	☐	Blood clotting disorder
9.	☐	☐	Sickle cell anemia / trait
10.	☐	☐	Breast problems / Surgery
11.	☐	☐	Asthma
12.	☐	☐	Lung problems / Tuberculosis
13.	☐	☐	Kidney / Bladder / Urinary Tract infection or problems
14.	☐	☐	Recurrent vaginal infections
15.	☐	☐	Pelvic infection / PID
16.	☐	☐	Abnormal Pap smear
17.	☐	☐	Cervical cryo, LEEP, Laser or Cone biopsy
18.	☐	☐	Diabetes
19.	☐	☐	Thyroid disease
20.	☐	☐	Liver disease / Hepatitis / Mono
21.	☐	☐	Gall bladder disease
22.	☐	☐	Past surgery(s)
23.	☐	☐	Past hospitalization(s)
24.	☐	☐	Vaccination for Hepatitis B
25.	☐	☐	Vaccination for Rubella / MMR

REVIEW OF SYSTEMS

	No	Yes	
Constitutional:			
26.	☐	☐	Generally healthy
Cardiovascular:			
27.	☐	☐	Swelling / Fluid retention in hands or feet

REVIEW OF SYSTEMS – CONTINUED

	No	Yes	
Hematological:			
28.	☐	☐	Easily bruised
29.	☐	☐	Varicose veins
Neurological:			
30.	☐	☐	Headaches (frequent / severe) / Migraine
31.	☐	☐	Numbness / Sensory loss
32.	☐	☐	Seizures
Respiratory / Chest:			
33.	☐	☐	Breast lump / discharge
34.	☐	☐	Shortness of breath
Eyes:			
35.	☐	☐	Blurred / Double vision (Not corrected by glasses or contacts)
Gastrointestinal:			
36.	☐	☐	Abdominal pain
37.	☐	☐	Bowel pain / Constipation / Diarrhea
38.	☐	☐	Rectal bleeding / Pain
Genitourinary:			
39.	☐	☐	Vaginal discharge, itching or burning
40.	☐	☐	Frequency or burning with urination
41.	☐	☐	Pelvic pain
ENT:			
42.	☐	☐	Ulcers / Sores in your mouth
Psychological:			
43.	☐	☐	Anxiety
44.	☐	☐	Depression
45.	☐	☐	Would you like a mental health referral today?
Skin:			
46.	☐	☐	Rash or itching

Patient Name:________________________ Age:_______ Medical Record #:________________ Date:________________

HEALTH HABITS / SOCIAL HISTORY

No	Yes	
☐	☐	Douches
☐	☐	Self breast exams
☐	☐	Smokes: _______ cigarettes per day.
☐	☐	Alcohol intake: ________ drinks per week.
☐	☐	Drugs use: daily / weekly / monthly. Type _________________
☐	☐	Alcohol and/or drugs cause problems in your life?
☐	☐	Others are concerned with your alcohol / drug habits?
☐	☐	Afraid of your partner(s) / others?
☐	☐	Parent(s) or guardian is aware of your visit today? (Only answer if under age 18.)

MENSTRUAL HISTORY

Age when period started: ________

Periods are: ☐ Regular ☐ Irregular ☐ Painful
Flow is: ☐ Light ☐ Moderate ☐ Heavy

Periods come every _________ days.

Bleeding lasts ___________ days.

When was the 1st **day** of your last period? ____________________

No	Yes	
☐	☐	Was your last period normal?
☐	☐	Do you think you might be pregnant?
☐	☐	Do you ever miss periods?
☐	☐	Do you ever have bleeding between periods?

SEXUAL HISTORY

Age at first intercourse: ______
# of sexual partners in last 30 days: ______
# of sexual partners in lifetime: ______
Partner(s): ☐ Male ☐ Female ☐ Both
Kind of sex (check all that apply): ☐ Vaginal ☐ Anal ☐ Oral
Do you have pain or bleeding with sex? ☐ No ☐ Yes
Have you ever been forced to have sex? ☐ No ☐ Yes
Do you consistently use condoms for safer sex? ☐ No ☐ Yes
Do you plan children in the future? ☐ No ☐ Yes ☐ Undecided
Planning a pregnancy within the next year? ☐ No ☐ Yes ☐ Undecided

Have you ever had the following?

No	Yes		
☐	☐	Chlamydia	Date last treated: ___________________
☐	☐	Gonorrhea	Date last treated: ___________________
☐	☐	Herpes	Date last treated: ___________________
☐	☐	HPV/warts	Date last treated: ___________________
☐	☐	PID	Date last treated: ___________________
☐	☐	Syphilis	Date last treated: ___________________
☐	☐	Trichomonas	Date last treated: ___________________
☐	☐	Currently experiencing itching, burning or unusual discharge?	
☐	☐	Did you douche, use a tampon, have bleeding or sex in the last 3 days?	

CONTRACEPTIVE HISTORY

Current method of birth control: ________________________________

How long have you used this method? ____________________________

What other methods of birth control have you used?

☐ Pills ________________	☐ Diaphragm	☐ Rhythm/Natural
☐ Depo Provera	☐ Cervical Cap	☐ Withdrawal
☐ Lunelle	☐ Male condoms	☐ Abstinence
☐ Evra Patch	☐ Female condoms	☐ Tubal ligation
☐ Nuva Ring	☐ Spermacide	☐ Vasectomy
☐ IUD ________________		
☐ Norplant		

What method, if any, do you want today? __________________________

PREGNANCY HISTORY

☐ Never Pregnant

Age at first pregnancy (at time of conception): _______

# of live births	_______	Date(s) ____________________
# of C-sections	_______	Date(s) ____________________
# of premature births	_______	Date(s) ____________________
# of miscarriages	_______	Date(s) ____________________
# of still births	_______	Date(s) ____________________
# of abortions	_______	Date(s) ____________________
# of ectopics	_______	Date(s) ____________________

I would like the following STI screening today:

☐ Chlamydia
☐ Gonorrhea
☐ HIV
☐ Syphilis
☐ Vaginitis

I would like information on the following:

	Given (Staff Initials)
☐ Birth Control Method(s) _________________	__________
☐ Emergency Hormonal Contraception	__________
☐ Preconception	__________
☐ Perimenopause	__________
☐ Smoking Cessation	__________

Patient Signature: ____ **Date:** ____________________

Comments:

☐ STI Risk Assessment done.
☐ Safer sex and condom use reviewed.
☐ EHC discussed / Fact Sheet N given.
☐ HIV pretest counseling done.
☐ Other ______________________.
☐ Pt. urged to discuss visit with parent or guardian.

Interviewer Signature: ____ **Date:** ____________________

Clinician Signature: ____ **Date:** ____________________