

Last/ First Name: _____
 Chart#: _____
 D.O.B.: _____

Date _____ Age _____
 May we say Planned Parenthood if we call? Yes No

Patient informed of required contact requirements.

Person to contact in an emergency: (cite relationship)
 # _____

Does this person know about your abortion? _____
 First day of last normal menstrual period: _____
 Was your last period normal? Yes _____ No _____

Pregnancy History:

Total times pregnant: # _____ (**Counting this pregnancy**)
 # of vaginal births _____ Date(s) _____
 # of C-sections _____ Date(s) _____
 # of Miscarriages _____ Date(s) _____
 # of ectopic (tubal) _____ Date(s) _____
 # of abortion(s) _____ Date(s) _____
 # of stillbirth(s) _____ Date(s) _____
 # of living children _____ Age(s) _____

Which birth control method were you using when you became pregnant this time?
 None Condoms/foam/spermicides
 Birth control pill Diaphragm/cervical cap
 Depo Provera injection Tubal Ligation/vasectomy
 Lunelle injection Norplant
 Nuvaring Evra patch
 IUD Is it still in place? Yes _____ No _____

Allergy History:

Are you allergic to or have you ever had a bad reaction to:
YES NO (Please check one)
 shellfish (iodine)?
 latex or bananas?
 antibiotics (List below)
 Novocain or Lidocaine
 any type of anesthesia?

List other allergies: _____

Medications:

Do you use any of the following medications?
YES NO (Please check one)
 asthma inhaler?
 steroids (like prednisone)?
 blood thinners (like coumadin, heparin, etc)

List all other medications taken & their purpose:

YES NO (Please check one)
 Do you smoke? If yes, # _____ packs per day
 Do you drink alcohol? If yes, # _____ drinks/ week
 History of drug addiction? Drug(s) _____
 Current use of recreational drugs?
 Type(s) _____
 How often? _____ Last use? _____

Do you now have or have you ever had:

- Yes No**
- Anemia / Sickle cell anemia
 - Blood clotting disease, like hemophilia
 - Leukemia OR any other blood problem
 - Asthma
 - Bronchitis / Pneumonia / Tuberculosis (circle)
 - Any other lung or breathing problem
 - Thyroid disease ↑ hyper ↓ hypo
 - Kidney (Renal) disease
 - Diabetes
 - Liver disease: Hepatitis/ Cirrhosis/ Mono/ Jaundice
 - Heart problems: heart attack/ surgery/ irregular heart beat/ mitral valve prolapse or: _____
 - Epilepsy/ Seizure disorder
 - Inflammatory bowel disease/ Colitis/ Crohn's Disease
 - Cancer _____
 - Breast lump
 - Stroke
 - Brain injury
 - Migraine headaches**
 - Phlebitis / Blood clots in legs or lungs
 - High blood pressure
 - Depression/ Psychiatric problems
 - Fibroids of the uterus
 - Herpes
 - HIV/ AIDS
 - CURRENT** Chlamydia or Gonorrhea Infection
 - Recent exposure to chlamydia or gonorrhea
 - CURRENT** abnormal vaginal discharge
 - CURRENTLY** breast feeding
 - CURRENT** vaginal bleeding or pelvic pain
 - CURRENT** cold symptoms and/or cough
 - Genetic condition /Chronic illness/ medical condition

List: _____
 List surgeries: _____

List hospitalizations: _____

Does anyone in your family have:

Yes No Age at diagnosis
 Breast cancer _____
 Ovarian cancer _____

I acknowledge that the above is correct & complete

Patient signature: _____ Date: _____
 Staff signature: _____ Date: _____

Staff comments if indicated (use back of page if needed):