

PLANNED PARENTHOOD OF SOUTHWEST & CENTRAL FLORIDA

MANATEE - SARASOTA - TAMPA - FT. MYERS - LAKELAND - WINTER HAVEN - PINELLAS
 (941) 567-3800 (941) 953-4060 (813) 980-3555 (239) 481-9999 (863) 665-5735 (863) 293-7494 (727) 898-8199

Revised 08/12/10

Implemented 09/08/10

Last/ First Name: _____

 Chart#: _____
 D.O.B.: _____

Date _____

Shaded areas indicate areas for review for HOPE

YES	NO	A. REVIEW OF SYSTEMS: GENERAL
		1. Is your health generally good? <input type="checkbox"/> exercise _____ times / week <input type="checkbox"/> eating habits (circle one) healthy fair poor
		2. Unexplained weight loss/ gain of more than 10 lbs. in the past yr?
		3. Night sweats / hot flashes?
		4. Cancer? If yes, where / when?
		5. Tobacco use? If yes, for how many years? _____ If yes, <input type="checkbox"/> smoking? How many/day? <input type="checkbox"/> chewing tobacco?
		6. Alcohol use? If yes, how many drinks/week?
		7. Are you being treated for any illness/condition now? If yes what?
		8. Do you currently take medicine: prescription, over-the-counter, or herbal? If yes, what? _____ <input type="checkbox"/> folic acid supplements? <input type="checkbox"/> asthma inhaler? <input type="checkbox"/> steroids (like prednisone)? <input type="checkbox"/> blood thinners (like coumadin, heparin, etc)
		9. Birth defects or genetic problems?
		10. Eye problems (except glasses or contacts)?
		CARDIO-RESPIRATORY
		11. Mitral valve prolapse?
		12. Heart murmur?
		13. <input type="checkbox"/> Varicose veins? <input type="checkbox"/> Swelling of legs/feet?
		14. Blood clots (head / leg / lungs)?
		15. Stroke or stroke-like problems?
		16. High blood pressure?
		17. High cholesterol?
		18. Chronic cough or other breathing problems / asthma?
		19. Tuberculosis or exposure to tuberculosis?
		GASTROINTESTINAL
		20. Stomach or bowel problems?
		21. Liver problems (hepatitis or tumor, etc.)?
		22. Gallbladder problems?
		GENITOURINARY
		23. Bladder, urine leaks or kidney problems?
		24. Uterine fibroids?
		25. Breast lump or nipple discharge?
		26. Endometriosis?
		27. Pain with sex? Other sex problems?
		28. Previous pap? When? _____ Result: _____
		29. Any abnormal paps? <input type="checkbox"/> Colposcopy <input type="checkbox"/> Cryo Surgery <input type="checkbox"/> LEEP surgery <input type="checkbox"/> Cone biopsy
		30. Age of first vaginal intercourse? _____
		31. Did your mother take DES when she was pregnant with you?
		32. History of sexually transmitted infection? Check type: <input type="checkbox"/> Chlamydia? <input type="checkbox"/> Gonorrhea? <input type="checkbox"/> Genital warts? <input type="checkbox"/> Herpes? <input type="checkbox"/> Syphilis? <input type="checkbox"/> PID <input type="checkbox"/> HIV/AIDS?
		MUSCULOSKELETAL
		33. <input type="checkbox"/> Arthritis? <input type="checkbox"/> Osteoporosis? <input type="checkbox"/> Other?
		SKIN
		34. <input type="checkbox"/> Acne or other skin problems? If yes, what? _____ <input type="checkbox"/> Tattoo? <input type="checkbox"/> Piercing? If yes, where?
		NEUROLOGICAL
		35. Migraine headaches / Aura (diagnosed by MD / NP / PA)?
		36. Seizures / epilepsy?
		37. Numbness in arms / legs (recurring)?
		PSYCHOLOGICAL
		38. Depression requiring treatment? Have you ever considered suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No Other psychological problems?

YES	NO	A. (cont'd) REVIEW OF SYSTEMS: ENDOCRINE	
		39. Thyroid problems?	
		40. Diabetes?	
		HEMATOLOGICAL/LYMPHATIC	
		41. Anemia (Low Iron)?	
		42. Sickle cell disease / trait?	
		43. Blood clotting disorder?	
		44. <input type="checkbox"/> Systemic Lupus Erythematosus <input type="checkbox"/> positive/ unknown antiphospholipid antibodies	
		ALLERGY	
		45. Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, to what? Type of reaction: <input type="checkbox"/> shellfish (iodine)? <input type="checkbox"/> latex or bananas? <input type="checkbox"/> antibiotics, if so what? _____ <input type="checkbox"/> Novocain or Lidocaine _____ <input type="checkbox"/> any type of anesthesia? _____	
		IMMUNIZATION (Check the ones you have received)	
		46. <input type="checkbox"/> Shingles vaccine	
		47. <input type="checkbox"/> Flu shot	
		48. Hepatitis B <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?	
		49. Human Papillomavirus (HPV) <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?	
		50. <input type="checkbox"/> Measles/Mumps/Rubella (MMR)?	
		51. <input type="checkbox"/> Meningococcal?	
		52. <input type="checkbox"/> Pneumococcal?	
		53. <input type="checkbox"/> Tetanus?	
		54. <input type="checkbox"/> Varicella (chicken pox)?	
		55. Other	
		B. HOSPITALIZATION AND SURGERIES	
		Year Reason	
		C. ACCIDENTS AND INJURIES	
		Year Reason	
		D. FAMILY HISTORY	
		Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Have your biological family (parents, brothers, sisters) had any of the following?	
		YES NO Diagnosis Relative	
		Osteoporosis?	
		Diabetes?	
		Heart disease / heart attack / stroke before age 50?	
		High cholesterol?	
		Genetic problems?	
		Cancer? If yes, please specify- _____	
		Blood clots?	
		High Blood pressure?	
		ADDITIONAL COMMENTS / EXPLANATIONS (by number)	

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E. PREGNANCY HISTORY never pregnant

Total times pregnant: # _____

of vaginal births _____ Last Date _____ (mon/yr)

of C-sections _____ Last Date _____ (mon/yr)

of Miscarriages _____ Last Date _____ (mon/yr)

of ectopic (tubal) _____ Last Date _____ (mon/yr)

of abortion(s) _____ Last Date _____ (mon/yr)

F. CONTRACEPTIVE HISTORY

Current birth control method? _____ How long used? _____

Any problems with this method? Yes No
 If yes, what? _____

What method do you want to use now? _____

Are you planning a pregnancy in the NEXT year? Yes No

WHICH OF THE FOLLOWING METHODS HAVE YOU USED IN THE PAST?

METHOD	COMMENT/PROBLEM
<input type="checkbox"/> Abstinence?	
<input type="checkbox"/> Tubal? <input type="checkbox"/> Vasectomy?	
<input type="checkbox"/> Birth Control Pill?	
<input type="checkbox"/> The Patch?	
<input type="checkbox"/> The Ring?	
Implant: <input type="checkbox"/> Norplant? <input type="checkbox"/> Implanon?	
<input type="checkbox"/> Depo-Provera (The Shot)?	
<input type="checkbox"/> IUD?	
<input type="checkbox"/> Condoms?	
<input type="checkbox"/> Diaphragm?	
<input type="checkbox"/> Emergency Contraception	
<input type="checkbox"/> Sponge? <input type="checkbox"/> Spermicide?	
<input type="checkbox"/> Rhythm?	
<input type="checkbox"/> NFP (Natural Family Planning)?	
<input type="checkbox"/> Withdrawal (pull out)?	

G. MENSTRUAL HISTORY

1. Age periods began? _____

2. Number of pads / tampons used on heaviest day? _____

3. Length of period? _____ (days) # of days between periods? _____

4. Are your periods usually regular? Yes No

5. Do you experience, before or with periods, Cramps?
 Bloating? Bowel problems? Emotional changes?

6. Do you have vaginal bleeding after sex? Yes No

7. Do you have vaginal bleeding between menstrual periods?
 Yes No

H. STI / HIV RISKS

Total number of sex partners in your lifetime? _____ MEN _____ WOMEN

How many sex partners have you had during the past year? _____

Does your partner have sex with men women both?

Do you have (check all that apply) vaginal oral anal sex?

COMMENTS

Have you ever used street drugs? If yes, when? _____

Have you received blood or blood products prior to 1992? _____

Were any of your partners: a street drug user?
 a Hemophiliac? infected with HIV / AIDS? MSM
 (men having sex with men)? _____

Have you ever shared needles?
 Examples: Injecting drugs, tattooing, piercing? _____

Client Signature Date

To the best of my knowledge the information I have provided is correct and complete.

STAFF COMMENTS (do not write anything in this space)

Year 1

Clinician Signature Date

Year 2

Clinician Signature Date

Year 3

Clinician Signature Date

History reviewed: _____

CA Signature Date

CA Signature Date

CA Signature Date