

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

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

BRIEF CONTRACEPTIVE HISTORY FORM (HOPE)

Date _____ Age _____	
Address _____	
Home Phone _____ Work Phone _____	
Emergency Contact Person _____ Phone # _____	
When did your last period start? _____ Was it normal for you? <input type="checkbox"/> Yes <input type="checkbox"/> No When not on birth control, have you ever gone months without getting a period? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last pregnancy _____ <input type="checkbox"/> N/A	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any abnormal bleeding or vaginal discharge?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had unprotected sex since your last period?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you think you might be pregnant?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you breastfeeding now?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco? <input type="checkbox"/> Smoking <input type="checkbox"/> Chewing. If yes, how much a day?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you allergic to any drugs, medications, or latex?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking any medications (including vitamins), herbs, or drugs? If yes, which ones?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you planning major surgery that will require long-term bed rest?
Have you had any of the following?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No	blood clot or blood clotting disorder — If yes, are you taking medicine now?
<input type="checkbox"/> Yes <input type="checkbox"/> No	heart attack or other heart disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	serious heart-valve problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	breast cancer or lumps in your breast
<input type="checkbox"/> Yes <input type="checkbox"/> No	other cancer — If yes, what kind?
<input type="checkbox"/> Yes <input type="checkbox"/> No	diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No	seizures
<input type="checkbox"/> Yes <input type="checkbox"/> No	high blood pressure
<input type="checkbox"/> Yes <input type="checkbox"/> No	high cholesterol
<input type="checkbox"/> Yes <input type="checkbox"/> No	gall bladder disease (not including having your gall bladder removed)
<input type="checkbox"/> Yes <input type="checkbox"/> No	severe long-term depression
<input type="checkbox"/> Yes <input type="checkbox"/> No	migraine headaches — If yes, do you ever have vision changes that <input type="checkbox"/> start before the headache <input type="checkbox"/> last up to one hour <input type="checkbox"/> go away before the headache begins
<input type="checkbox"/> Yes <input type="checkbox"/> No	liver problems

Sample Brief Contraceptive Hx Form

III-A-4

Revised June 2009

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<input type="checkbox"/> Yes <input type="checkbox"/> No	lupus (Systemic Lupus Erythematosus)
<input type="checkbox"/> Yes <input type="checkbox"/> No	bone problems — fragility fractures or osteoporosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	eating disorder
<input type="checkbox"/> Yes <input type="checkbox"/> No	problems with vaginal muscles or severe constipation
<input type="checkbox"/> Yes <input type="checkbox"/> No	bariatric (weight loss) surgery? If yes, what kind?
<input type="checkbox"/> Yes <input type="checkbox"/> No	other serious illness — If yes, what?
Family History	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a father or brother had a heart attack or stroke before age 55?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a mother or sister had a heart attack or stroke before age 65?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a family member(s) had a serious blood clot (DVT) or blood clotting disorder?
Past experience with hormonal birth control	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you used hormonal birth control before? If yes, circle which one: Pills/POPS Patch Ring DMPA Norplant/Implanon If birth control pills, which pill(s) _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problems with them? If yes, describe: _____
General Health Questions	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Last routine breast and pelvic exams were normal? <input type="checkbox"/> N/A If not normal, please explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Last mammogram was normal <input type="checkbox"/> N/A
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a Pap test?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you having intercourse? If yes , circle all that apply: Oral sex Vaginal sex Anal sex New relationship Long-term relationship Multiple partners Do you use condoms? <input type="checkbox"/> always <input type="checkbox"/> sometimes <input type="checkbox"/> never

Client Signature _____

Date _____

