Planned Parenthood®
of Southwest and Central Florida, Inc.

Last/ First Name: ______________________________

Chart#: ________________________

D.O.B.:__________________________

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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?

antiseptic solution

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?

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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

Lupus or Antiphospholipid antibody syndrome

List: _________________________________

List surgeries:_________________________________

____

List hospitalizations:___________________________

____

Does anyone in your family have:

Yes No	Age at diagnosis
Breast cancer	____________
Ovarian cancer	____________
History of heart attack before 50	

I acknowledge that the above is correct & complete

Patient signature: _______________________ Date: _______

Staff signature: _________________________ Date: _______

Physician signature: ______________________ Date: _______

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