Planned Parenthood

INITIAL HISTORY

Patient ID# ____________________

Name ________________________ DOB ____ / ____ / ____ Age ______ Date ______________

Marital Status: ☐ Never married ☐ Married ☐ Widowed ☐ Other

A: REVIEW OF SYSTEMS

YES	NO	GENERAL
		1. My health is generally good
		2. Unexplained weight loss or gain of more than 10 lbs.
		3. Night sweats/hot flashes
		4. Cancer – If yes, where/when?
		5. Smoke cigarettes – If yes, how many packs per day and for how many years?
		6. Alcohol use – If yes, how many drinks per week?
		7. Birth defects or genetic problems
		8. Are you being treated for any illness/condition now? If yes, what?
		9. Do you currently take prescription medication, over the counter or herbal? If yes, name:
		EYES
		10. Eye problems (except glasses or contacts)
		EARS/NOSE/MOUTH/THROAT
		11. Hearing problems
		12. Frequent nosebleeds
		13. Frequent sore throat
		CARDIOVASCULAR
		14. Mitral Valve Prolapse
		15. Heart murmur/disease
		16. Varicose veins
		17. Blood clots (head/leg/lungs)
		18. Stroke or stroke-like problems
		19. High blood pressure
		20. High cholesterol
		RESPIRATORY
		21. Chronic cough/other breathing problems/Asthma/Sleeping disorder–Apnea
		22. Tuberculosis or exposure to Tuberculosis/Hx Pneumonic/Bronchitis
		GASTROINTESTINAL
		23. Stomach or bowel problems
		24. Liver problems (hepatitis or tumor, etc.)
		25. Gall bladder problems
		GENITOURINARY
		26. Bladder or kidney problems
		27. Urinary problems
		28. Uterine fibroids/infections
		29. Ovarian cysts
		30. Breast lump or discharge/cancer
		31. Vaginal discharge that itches/burns or has a bad odor
		32. Endometriosis
		33. Pain during sex
		34. Date of last pap smear:
		35. History of Abnormal paps: Date:
		Result: Colposcopy ☐ Yes ☐ No
		Treatment: ☐ Cryotherapy ☐ LEEP ☐ Laser ☐ None
		Follow-up Paps: ☐ Normal ☐ Abnormal ☐ None
		☐ Other
		36. Did your mother take DES when she was pregnant w/you to prevent a miscarriage?
		37. History of sexually transmitted infection? Check type: ☐ Chlamydia ☐ Gonorrhea ☐ Genital warts/HPV ☐ Herpes ☐ Syphilis ☐ PID ☐ Hepatitis B ☐ Trichomonas
		MUSCULOSKELETAL
		38. Arthritis or osteoporosis
		SKIN
		39. Acne or other skin problems – If yes, what?
		NEUROLOGICAL
		40. Migraine headaches (diagnosed by Dr./NP/PA)
		Do you ever experience any of the following before a headache: ☐ Double vision, blindness ☐ Flashing lights and wavy lines ☐ Numbness or weakness ☐ Speech problems ☐ None of these
		41. Seizures/epilepsy
		42. Numbness in arms/legs (recurring)

A: REVIEW OF SYSTEMS

YES	NO	PSYCHOLOGICAL
		43. Depression, requiring treatment
		ENDOCRINE
		44. Thyroid problems
		45. Diabetes/Diabetes during pregnancy
		HEMATOLOGICAL/LYMPHATIC
		46. Anemia (HIV/AIDS)
		47. Sickle cell disease/trait
		48. Blood clotting disorder/bleeding disorder
		ALLERGY/IMMUNOLOGY
		49. Rubella (German measles)
		50. HPV Gardisil immunization? Did you complete all 3 injections?
		51. Vaccine for Rubella (German measles)
		52. Tetanus immunization? Date:
		53. Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, what? ____________

B: HOSPITALIZATION AND SURGERIES

YEAR	REASON

C: FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

Has your biological family (parents, brothers, sisters) had any of the following?

YES	NO	DIAGNOSIS	RELATIVE
		Osteoporosis	
		Diabetes	
		Heart attack/Stroke before age 50	
		High blood pressure	
		Genetic problems	
		Cancer	
		Blood Clotting Disorder	
		Thyroid Problems	

STAFF COMMENTS/EXPLANATIONS (by number)

Patient ID#________________ Name______________________________ DOB____ / ____ /____ Date __________

D: PREGNANCY HISTORY

☐ Never pregnant

Total # of pregnancies________

Number of Live Births________

Number of Miscarriages _____

Number of Abortions ________

Are you currently breastfeeding?____________

Number of Tubal Pregnancies____________

Date of Last Delivery ____________

Date of Last Abortion ____________

Complications: Pregnancy/Abortion______________________

E: CONTRACEPTIVE HISTORY

Current birth control method:

How long used?

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

What methods 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:

YES	NO	METHOD	COMMENTS/PROBLEM
		Abstinence	
		☐ Tubal ☐ Vasectomy ☐ Hysterectomy	
		Oral Contraceptives	
		Norplant	
		Depo-Provera (injection)	
		Lunelle (injection)	
		IUD	
		Condoms	
		☐ Diaphragm ☐ Cap	
		Sponge	
		☐ Rhythm ☐ NFP	
		Withdrawal	
		Patch	
		Ring	

F: SOCIAL HISTORY

YES	NO	Have you recently experienced:	COMMENTS:
		☐ Emotional ☐ Relationship problems	
		Problems in: ☐ Living arrangements ☐ School	
		Are you physically abused?	
		Has anyone forced you to have sex?	
		Are you afraid of your ☐ Partner? ☐ Family member?	

Comments:

G: MENSTRUAL HISTORY

1) Age periods began:

2) Number of pads/tampons used on heaviest day:

3) Length of period in days:

4) Are your periods usually longer? ☐ Yes ☐ No

5) Last period started on:
It seemed: ☐ Normal ☐ Not normal

6) Do you experience, before or with periods:
☐ Cramps ☐ Bloating ☐ Bowel problems ☐ Emotional changes

7) Do you have vaginal bleeding after sex? ☐ Yes ☐ No

8) Do you have vaginal bleeding between menstrual periods?
☐ Yes ☐ No

STI/HIV RISKS

Number of sex partners in your life: Male Female

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

How old were you when you first had sex?

Do you have: ☐ anal ☐ oral ☐ vaginal

YES	NO	COMMENTS
		Have you ever used street drugs? If yes, when and what?
		Have you ever received blood or blood products since 1978?
		Was any partner: ☐ a street drug user ☐ a Hemophiliac, or ☐ infected with HIV/AIDS and/or Hepatitis? ☐ Bisexual ☐ Hx of multiple sex partners
		Have you ever shared needles? (eg: injecting drugs, tattooing, piercing)

Comments:

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

Client Signature Date

Staff Signature Date