Planned Parenthood of the Rochester/Syracuse Region
MEDICAL HISTORY

Patient Name_____
Date of Birth_____
Chart #_____

Date_____

Yes	No	
♦	♦	Receiving medical care with another health provider? Why? _____
		When was your last pap smear_____
♦	♦	Allergic to any medications, anesthesia, latex or shellfish **List:**_____
♦	♦	Currently taking medications (including herbal remedies and vitamins **List:**_____
♦	♦	Past surgery(s)/hospitalization(s) **List:**_____

FAMILY HISTORY

Yes	No	
♦	♦	Are you adopted?
♦	♦	Did your mother take DES while she was pregnant with you? (if you were born before 1971)

Does your Mother (M), Father (F), Sister (S), Brother (B), have any of the following?

Yes	No		Who
♦	♦	Increased Cholesterol	_____
♦	♦	Diabetes	_____
♦	♦	Increased Blood Pressure	_____
♦	♦	Cancer	_____
♦	♦	Breast Cancer	_____
♦	♦	Heart attack before 50	_____
♦	♦	Other_____	_____

MENSTRUAL HISTORY

Age when period started:_____
Age when you first had sex: _____

Periods are: ♦ Regular ♦ Irregular ♦ Painful
Flow is: ♦ Light ♦ Moderate ♦ Heavy

Periods come every_____days
Bleeding lasts_____days

Problem with periods: _____

Your Past Medical History – Have you had or do you now have:

	Yes	No		STAFF NOTES
1.	♦	♦	Cancer Type: _____	
2.	♦	♦	Stroke	
3.	♦	♦	High blood pressure	
4.	♦	♦	Heart disease	
5.	♦	♦	Blood clotting disorder	
6.	♦	♦	Blood clots in veins or lungs	
7.	♦	♦	High cholesterol/triglycerides	
8.	♦	♦	Heart murmur/MVP/palpitations	
9.	♦	♦	Anemia (low iron)	
10.	♦	♦	Sickle cell anemia/trait	
11.	♦	♦	Blood transfusion	
12.	♦	♦	Broken bones/fractures	
13.	♦	♦	Thyroid disease	
14.	♦	♦	Seizures/epilepsy Last seizure:_____	
15.	♦	♦	Neurological disease	
16.	♦	♦	Diagnosed migraine headaches	
17.	♦	♦	Other severe headaches	
18.	♦	♦	Numbness/sensory loss	
19.	♦	♦	Eye problems except glasses/contacts	
20.	♦	♦	Stomach/intestinal problems	
21.	♦	♦	Liver disease/hepatitis Type:_____	
22.	♦	♦	Bladder/kidney problems	
23.	♦	♦	Diabetes	
24.	♦	♦	Asthma/breathing problems	
25.	♦	♦	TB	
26.	♦	♦	Chronic rash/itching	
27.	♦	♦	Breast disease/surgery	
28.	♦	♦	Breast lump or discharge	
29.	♦	♦	Recurrent vaginal infections	
30.	♦	♦	Pelvic pain	
31.	♦	♦	Abnormal pap smear/Colposcopy	
32.	♦	♦	Cervical LEEP/Laser/Cone/cryo	
33.	♦	♦	Endometriosis/fibroids/ovarian cysts	
34.	♦	♦	Depression-mild/moderate/severe	
35.	♦	♦	Severe mood swings	
36.	♦	♦	Anorexia/bulimia	
37.	♦	♦	Other psychiatric problems	
38.	♦	♦	Are you in counseling?	

Have you had the following:

♦ Don't know ♦ Never had an STI

♦ HPV/Warts	♦ Herpes	♦ Syphilis
♦ Chlamydia	♦ Gonorrhea	♦ Scabies
♦ Trichomonas	♦ Molluscum	♦ PID

Dates treated:_____

(OVER)

Patient Name_____
Date of Birth_____
Chart #_____

Pregnancy History ♦**Never Pregnant**

Number of Live Births _____ Year (s)_____
Number of C-Sections _____ Year(s)_____
Number of Premature Births _____ Year(s)_____
Number of Miscarriages _____ Year(s)_____
Number of Still Births _____ Year(s)_____
Number of Ectopics (tubal) _____ Year(s)_____
Number of Abortions _____ Year(s)_____
Number of Living Children _____ Age(s)_____

Have you had any of the following problems with a pregnancy:

♦ Gestational diabetes ♦ High blood pressure
♦ Hemorrhage ♦ Other_____

CONTRACEPTIVE HISTORY *CHECK ALL THAT APPLY*

Now	Past		Now	Past			
♦	♦	Pill_____	♦	♦	Abstinence	**IUDs**	
♦	♦	Depo Provera (shot)	♦	♦	Tubal Ligation	♦	**Mirena**
♦	♦	Lunelle	♦	♦	Vasectomy	♦	**Paragard**
♦	♦	Nuva Ring	♦	♦	Foam/Sponge/Film	Date Placed _____	
♦	♦	Patch	♦	♦	Rhythm/Natural	Date Removed _____	
♦	♦	Norplant	♦	♦	Female condom	Date Expires _____	
♦	♦	Withdrawal	♦	♦	Condom	**Now**	**Past**
						♦	♦ Implanon

Comments or problems with methods(s):_____
_____

SOCIAL HISTORY/HEALTH HABITS

These questions may seem personal but they help to evaluate your health. Please answer only the questions you feel comfortable answering.

CHECK OR FILL IN BLANKS TO ALL THAT APPLY

♦ Self Breast Exam ♦ Calcium Supplement
♦ Exercise ♦ IV Drugs
♦ Douching ♦ Street Drugs
Smokes ____ packs per day Alcohol ____ drinks per week

Yes	No				
♦	♦	Sexually Active	♦ Anal	♦ Oral	♦ Vaginal
♦	♦	Sexual Partner(s)	♦ Male	♦ Female	♦ Both
♦	♦	More than one sex partner in last year/new partner			
♦	♦	Use condoms	♦ Every time	♦ Sometimes	♦ Never
♦	♦	Request testing for sexually transmitted infections			
♦	♦	Questions/concerns about sex			
♦	♦	Emotional/relationship problems			
♦	♦	Have you been or are you currently experiencing any emotional, physical or sexual abuse?			
♦	♦	Would you like to speak with a clinician/counselor at this time?			
♦	♦	Would you like referral information?			
♦	♦	Alcohol and/or drugs cause problems in your life			
♦	♦	Others concerned with your alcohol/drug habits			
♦	♦	Parents aware of your visit today **(only answer if under age 18)**			

STAFF NOTES

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Annual Review #1: Staff Signature: _____ **Date:** _____

Annual Review #2: Staff Signature: _____ **Date:** _____