Planned Parenthood® of the Rochester/Syracuse Region Inc.

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
Cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe
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/Gallbladder disease/hepatitis	
22.	☐	☐	Bladder/kidney/Urethra 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?	
39.	☐	☐	SLE (Lupus)	

Anti phospholipid antibodies
☐ pos ☐ neg ☐ unknown

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 Vaginal Deliveries _____ 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 Ectopic (tubal)Pregnancies _____ 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 ☐ Genetic Abnormalities
☐ Hemorrhage ☐ Other_____________________

CONTRACEPTIVE HISTORY *CHECK ALL THAT APPLY*

Now	Past		Now	Past		IUDs
☐	☐	Pill__________	☐	☐	Abstinence	☐ **Mirena**
☐	☐	Depo Provera (shot)	☐	☐	Tubal Ligation	☐ **Paragard**
☐	☐	Lunelle	☐	☐	Vasectomy	Date Placed _________
☐	☐	Nuva Ring	☐	☐	Foam/Sponge/Film	Date Removed _______
☐	☐	Patch	☐	☐	Rhythm/Natural	Date Expires ________
☐	☐	Norplant	☐	☐	Female condom	**Now Past**
☐	☐	Withdrawal	☐	☐	Condom	☐ ☐ 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 ☐ Outercourse
☐	☐	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)**

Patient Signature: ______________________________ **Date:** ____________

Staff Signature: ______________________________ **Date:** ____________

Annual Review #1: Staff Signature: ________________________ **Date:** ____________ **Patient initials**______

Annual Review #2: Staff Signature: ________________________ **Date:** ____________ **Patient initials**______

(Rev 10/10)