

# Medical History

## Planned Parenthood of Southeast Ohio

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_ Marital Status \_\_\_\_\_

### General Information

What is the purpose of your visit today? \_\_\_\_\_ Do you have a doctor for other medical care?  Yes  No

Have you ever had a pelvic exam?  Yes  No Do you eat healthy?  Yes  No Do you exercise regularly?  Yes  No

Are you allergic to any medications, metals, or iodine?  Yes  No Type of Exercise \_\_\_\_\_

List: \_\_\_\_\_ Amount Per Week \_\_\_\_\_

Are you presently taking medication (prescription or over-the-counter) vitamins or herbal supplements?  Yes  No

List: \_\_\_\_\_

In a typical week, how often do you: Use alcohol \_\_\_\_\_ times a week. Use street drugs/marijuana \_\_\_\_\_ times a week.

How many cigarettes/cigars do you smoke? \_\_\_\_\_ per day How many years have you smoked \_\_\_\_\_

Have you ever quit smoking?  Yes  No Do you want to quit now?  Yes  No

How many cups of beverages containing caffeine do you drink a day \_\_\_\_\_

### Menstrual / Pregnancy / Sexual History

Age periods began \_\_\_\_\_

First day of last normal period \_\_\_\_\_

Number of days between day 1 of period & day 1 of next period \_\_\_\_\_

Number of days you flow \_\_\_\_\_

Is your flow  Light  Medium  Heavy

Number of pads or tampons used per day \_\_\_\_\_

Do you experience cramps?  Yes  No

Are you currently sexually active?  Yes  No

My sexual partner(s) are  Male  Female  Both

Have any of your partner(s) used IV drugs?  Yes  No  Unknown

Have any of your partner(s) had any blood transfusions?  Yes  No  Unknown

Have you ever had sex with a man who has had male-to-male sexual contact?  Yes  No  Unknown

Your current types of intercourse are:  Vaginal  Anal  Oral

Number of sexual partners: Now \_\_\_\_\_

Last 12 months \_\_\_\_\_

Lifetime \_\_\_\_\_

Age of your first intercourse \_\_\_\_\_

Are you currently pregnant?  Yes  No

If so, is this your first pregnancy?  Yes  No

Age at first pregnancy \_\_\_\_\_

Any problems with pregnancies (i.e. toxemia (high blood pressure), diabetes, genetic abnormalities, etc.)?  Yes  No

Specify: \_\_\_\_\_

List the total number of times pregnant \_\_\_\_\_

Number of live births \_\_\_\_\_

Date(s) \_\_\_\_\_

Number of living children \_\_\_\_\_

Number of premature births \_\_\_\_\_

Number of vaginal deliveries \_\_\_\_\_

Number of C-sections \_\_\_\_\_

Number/Date(s) of abortions \_\_\_\_\_

Number/Date(s) of miscarriages \_\_\_\_\_

Number/Date(s) of still births \_\_\_\_\_

Number/Date(s) of ectopic (tubal) pregnancies \_\_\_\_\_

Date(s) \_\_\_\_\_

Do you want children in the future?  Yes  No  Unsure

Are you currently breast feeding?  Yes  No

### Contraceptive History

In the past, what birth control methods have you used?

- pill  sponge  withdrawal / pull-out  norplant  vasectomy
- condoms  diaphragm  natural / rhythm  depo provera  none
- spermicide / foam  cervical cap  IUD type: \_\_\_\_\_  tubal ligation  other \_\_\_\_\_

Any problems with methods used? \_\_\_\_\_

What method of birth control do you want to use now? \_\_\_\_\_

Pill names and dates: \_\_\_\_\_ Depo Provera dates: \_\_\_\_\_

