

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

ANNUAL/REVISIT HISTORY / MALE – On-Line

Date: _____

Name: _____ SS# _____ Date of Birth: _____ Age: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Can we write / call you identifying ourselves as Planned Parenthood? [] Yes [] No. If answer is no, you will be contacted by "MAX".

Emergency Contact _____ Phone _____ Address _____

Relationship _____

Do you have a job? ___no ___yes, What is your monthly pay?_____ How many people do you support? _____

Are you a student? ___no ___yes, What grade did you last finish? _____

Do you have Medicaid or any other insurance? ___no ___yes Please write name _____

Are you allergic to any medications? ___no ___yes, please list _____

Reason for today's visit: _____

Y e s	N o	Medical History Are you experiencing?	Staff Use Only	Y e s	N o	Current Health Practices Do You
		1. Unusual discharge from the penis?				12. Smoke cigarettes: Amount/day _____
		2. Pain, burning or difficulty with urination?				13. Use alcohol: Amount/week _____
		3. Frequent urination or blood in urine?				14. Use street drugs: Type _____
		4. Pain or bleeding with sex or ejaculation?				SINCE YOUR LAST VISIT HAVE YOU HAD:
		5. Rectal pain, bleeding or discharge?				15. Illness, surgery, hospitalization
		6. Bumps or sores on your penis or genital area?				16. Jaundice (yellow skin or eyes), hepatitis, mononucleosis
		7. Have you recently taken antibiotics for infection?				17. Any changes in the health of close family members? (heart attack, stroke, diabetes, cancer, cholesterol, death)
		8. Have you or your partner had more than one sexual partner in the past three months?				18. Are you allegeric to any medicine? What: _____
		9. Has your partner(s) had bumps, sores or discharge in genital area?				19. Are you in pain today? Please circle re: severity 0 1-2 3-4 5-6 7-8 9-10
		10. Has your partner recently been treated for a sexually transmitted disease?				
		11. Are you using condoms for every sex act?				Location of today's pain _____

Please list all medications or drugs you are using now or take frequently, including over-the-counter medications, herbs and vitamins _____

To the best of my knowledge, the above information is complete and accurate

Client signature: _____

Date: _____

Initial Medical History – On-Line

Welcome to Planned Parenthood[®] of Southern New Jersey. These questions will help us assess your health needs. This is a confidential record of your health history.

Name _____ Today's date _____ Birth date _____ Age _____

Race: White ___ Black ___ Native American ___ Asian ___ Ethnicity: Hispanic ___ Non-Hispanic _____

Are you **ALLERGIC TO ANY MEDICATIONS OR ANY OTHER SUBSTANCE?** NO ___ Yes ___

If yes, please list: _____

CONTRACEPTIVE HISTORY

Yes No

- When you have intercourse, do you use a condoms?
- Have you and your partner used any other type of birth control? If so, what _____

PAST/PRESENT MEDICAL HISTORY

1. General

YES NO PLEASE CHECK BELOW

- My health is generally good
- Recent weight gain or loss
- Any cancer, genetic, or hereditary conditions
- Hepatitis A, B, C /Mononucleosis
- Immunizations up to date (Measles, Mumps, Rubella, Hepatitis)

2. Cardiovascular

- Mitral Valve Prolapse
- Heart Murmur/Heart palpitations
- Blood Clots

3. Neurologic

- Diagnosed Migraines
- Persistent numbness, tingling of arms or legs
- Seizure disorder/Epilepsy

4. Musculoskeletal

- Arthritis

5. Eyes

- Eye disorders
- Do you wear glasses or contact lenses

6. Gastrointestinal

- Gallbladder disease or liver disease

7. Respiratory

YES NO

- Breathing problems/Asthma
- Tuberculosis

8. Hematologic

- Anemia/ low iron
- Sickle cell anemia /trait/ thalassemia
- Blood clotting disorder/Leukemia
- Ever have a blood transfusion, what year? _____

9. Endocrine

- Thyroid disease
- Diabetes/Diabetes

10. Ears, Nose, Throat, Mouth

- Hearing problems
- Frequent nosebleeds
- Gum disease/chronic strep throat infections

11. Psychological

- Under the care of a psychiatrist or therapist
- History of depression/anxiety disorder/frequent mood swings

NAME _____ DATE _____ CHART# _____

FAMILY HISTORY Indicate which people in your family have had any of the following diseases
(F) father, (M) mother, (B) brother, (S) sister

DOES ANY ONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING DISEASES: NO _____ YES _____ if yes, please check below

_____ Blood clot(s) _____ Stroke, Heart Attack, Heart Disease (age of onset: _____)
 _____ Diabetes _____ Breast, Prostate, or Testicular Cancer (age of onset: _____)
 _____ High Blood Pressure _____ Other Cancer _____

SOCIAL HISTORY

- YES NO
- Do you smoke? If so, how many cigarettes per day? _____
 - Do you drink alcohol? If so, how often/how much? _____
 - Do you or your partner use street or IV drugs? If so, what? _____
 - Would you like to receive information on where to get help for a drug or alcohol problem?
 - Do you want to discuss problems related to rape, incest or domestic violence?
 - Do you exercise regularly?

SEXUAL HISTORY

These questions may seem personal but they help us to evaluate your health. All information is confidential. Please answer only the questions you are comfortable answering.

- YES NO
- Have you had sexual intercourse? Age first time _____
 - Are you currently in a sexual relationship? Is your sexual contact: all that apply Vaginal Anal Oral Other
 - Have you had more than one partner in the past year? _____ Are your partner(s) Male Female Both
 - Do you practice safe sex? Consistent condom use?
 - Do you want to be tested for sexually transmitted infections and/or HIV?
 - Have you ever impregnated a woman? Number of pregnancies _____ Number of children _____

Do you have any questions or concerns about sex that you would like to discuss today? _____

To the best of my knowledge, the information on this history form is complete and correct.

Patient signature _____ Date _____

Sign at initial medical visit and annual update

(REMEMBER--a new medical history form needs to be completed every 3 years by client)

Clinician Signature _____ Date _____

Clinician Signature _____ Date _____

Clinician Signature _____ Date _____