

Reproductive Health Services of Planned Parenthood of the St. Louis Region

MEDICAL HISTORY

Note to Patient completing this form: For your safety, please provide complete and accurate information below:

Yes No

Are you **ALLERGIC** to any medications?

Name of Medication	What Happens?

Yes No

Are you allergic to latex?

If Yes, what happens? _____

Are you allergic to any food or product we should be aware of?

If yes, what happens? _____

Yes No

Are you **TAKING** any medications, vitamins or herbal supplements?

Name of Medication/Vitamin/Herb	What do you take it for?

Yes No

Do you use any marijuana, cocaine, heroin, meth or other drugs?

If yes, which one(s) and how often? _____

Are you taking Steroids (e.g. prednisone)? If yes, for what? _____

Do you use tobacco (Cigarettes, Chewing)? Packs/Use per day? _____

Yes No

Do you have Asthma?

Do you use an inhaler? Type _____

Date you last used your inhaler or nebulizer: _____

Do you use other asthma medications? _____

What causes your asthma symptoms? _____

Have you been hospitalized overnight or had a breathing tube for your asthma? If Yes, when? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Yes No

High Blood Pressure (Hypertension)?

Stroke?

Blood clots in your legs, arms or lungs (DVTs)?

Have you been diagnosed with a bleeding disorder?

Heart Attack?

Heart valve problems?

Migraine Headaches?

If yes, do you ever have any of these with or before a migraine headache?

Spots/flashes of light, squiggly lines or loss of vision?

Difficult speaking or slurred speech?

Numbness, weakness or tingling of arms or hands?

Yes No

Epilepsy, seizures or blackouts?

Brain tumors?

Been diagnosed with a mental or emotional illness?

If yes, what was the diagnosis (i.e. depression, Bi-Polar, etc.)? _____

Yes No

Diabetes? Do you take Insulin? _____

Auto Immune disease/condition (Lupus, rheumatoid arthritis, other)?

Anemia or Sickle cell disease?

Liver problems?

Kidney problems?

Inflammatory bowel disease (i.e. IBS, Crohn's, Ulcerative Colitis)?

Gallbladder problems? (Except gallbladder removal)

Cancer of any kind?

Breast cancer or lumps?

Pelvic infection? If Yes, When: _____

Abnormal Pap smear?

If Yes, when? _____ What was the problem? _____

Did you have surgery on your cervix (i.e. LEEP, freezing, laser therapy)? _____

Yes No

Do you have a vaginal or sexually transmitted infection **NOW**?

If yes, which? _____

Are you currently taking antibiotics? If yes, what is the name? _____

Notes: _____

Patient Name (Print) _____ Date of Birth _____ Code # _____

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Yes No Are you currently under a physician's care for any reason?

Reason _____

Have you ever had Serious Illnesses?

What? _____

Have you ever had?

Yes No

Hospitalizations (overnight)?

Reason	Date

Yes No

Surgeries?

Type of surgery	Date

Yes No

Have you had conscious sedation/anesthesia?

Have you ever had an abnormal reaction to anesthesia?

Is there any other information in your medical history we need to know?

Yes No

What? _____

PREGNANCY HISTORY:

When was the first day of your last period? _____

How many pregnancies have you had, including this pregnancy? _____

Yes No

Are you breast feeding currently?

Have you had excessive nausea & vomiting with this pregnancy?

Deliveries

Year	Weeks/ Months pregnant	Vaginal Delivery	C-Section Delivery	Problems
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

Abortion/Miscarriage/Ectopic

Year	Weeks Months	Mis- carriage	In-Clinic Surgical abortion	Pill or Medication abortion	Ectopic (tubal pregnancy)	Problems
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

(Check all that apply)

Gestational Diabetes Preterm labor Blood transfusion

Genetic abnormalities High Blood Pressure Other _____

CONTRACEPTIVE HISTORY-Have you ever used:

(Check all that apply)

Pill Type: _____ Patch Ring

Depo Provera ("shot") Implant

IUD (type) _____ Condom (male or female)

Rhythm/Natural Abstinence Cervical Cap/ Diaphragm

Vasectomy

Yes No

Do you have an IUD in place NOW?

What type of birth control do you want after your abortion? _____

INFORMED TO BRING INHALER/TESTING SUPPLIES _____

Reviewed by _____ Date: _____

Notes: _____
