

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

MEDICAL HISTORY

Form Completed by Patient Interview with Staff Member

Date Completed _____

- Yes No**
- Are you allergic to any medications?
List: _____
- Are you allergic to latex? _____
- Are you taking any medications (including herbals and vitamins)?
List: _____
- Do you use tobacco (Cigarettes, Chewing)?
How much _____
- Are you breast feeding currently? _____
- Do you take Steroids? How long? _____
- Do you have an IUD in place? _____
- Have you had excessive nausea & vomiting with this pregnancy? _____

HAVE YOU EVER HAD?

- Yes No**
- Have you used conscious sedation/anesthesia?
 Abnormal reaction to anesthesia?
- Auto Immune disease/condition (Lupus, rheumatoid arthritis, other)?
- Anemia or Sickle cell disease?
- Asthma:
 Do you use an inhaler? Type _____
 Other asthma medications? _____
Date of last attack? _____
- What causes your asthma symptoms? _____
- Bleeding (blood clotting) problems?
- Cancer
- Heart Attack or serious heart valve problems?
- Hypertension (High Blood Pressure)?
- Stroke?
- Thrombophlebitis (Blood clots in your legs, arms or lungs)?
- Migraine Headaches? If yes, do you ever have any of these with/
before headache:
 Vision changes? (not including light sensitivity)
 Speech problems?
 Numbness, weakness or tingling of arms or legs?
- Epilepsy, seizures or blackouts?
- Brain tumors?
- Diabetes?
- Breast cancer or lumps?
- Liver problems?
- Kidney problems?
- Inflammatory breast disease?
- Gall bladder problems (Not including having your gall bladder
removed)?
- Severe long term depression?
- Pelvic infection?
- Abnormal pap smear?
- Active Sexually transmitted infections?
If yes, which? _____

ARE YOU UNDER A PHYSICIAN'S CARE FOR ANY REASON?

- Yes No**
- Reason: _____

HAVE YOU EVERY HAD?

- Yes No**
- Serious Illnesses? _____
- _____
- _____

HAVE YOU EVERY HAD?

- Yes No**
- Hospitalizations (overnight)?
_____ Date _____
_____ Date _____
_____ Date _____
- Surgeries? _____ Date _____
_____ Date _____
_____ Date _____

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? _____
- Number of times pregnant (including this pregnancy) _____
- Number of Live Births _____ Date(s) _____
- Number of C-Sections _____ Date(s) _____
- Number of Living Children _____
- Number of Miscarriages _____ Date(s) _____
- Number of Still Births _____ Date(s) _____
- Number of Ectopics (tubal) _____ Date(s) _____
- Number of SURGICAL Abortions _____ Date(s) _____
- Number of MEDICATION Abortions _____ Date(s) _____

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH A PREGNANCY?

- Gestational Diabetes Preterm labor
- Genetic abnormalities High Blood Pressure
- Other _____

CONTRACEPTIVE HISTORY

(Check all that apply)

- Pill Type: _____ Condom
- Patch Cervical Cap Vasectomy
- Ring Diaphragm
- Depo Provera (DMPA) Female Condom
- Lunelle Foam /Sponge/Film
- Norplant Rhythm/Natural
- IUD (type) _____ Abstinence

WHAT TYPE OF BIRTH CONTROL DO YOU WANT AFTER YOUR ABORTION?

Interviewed by _____

Reviewed by _____

Date Reviewed _____

Notes: _____

Patient Name _____ Date of Birth _____ Code # _____