Planned Parenthood
Surgical Health Services of North Texas, Inc.

FEMALE MEDICAL HISTORY

In general, all information on this chart is confidential. For your safety and the safety of others, we are required by law to report past or present child abuse.*

Please Print Today's date: ________________

Name: ____________________ Birthdate:________________ Age: ___________

Address____________________ City ____________________ State _____ Zip: ________

County ________________ Marital Status (check one) : Married _______ Single _______

Home Phone: ____________________ Work Phone: ____________________

Race: ____________________ Weekly Income: __________________ # of people you support: ____________

If we need to call you, may we say Planned Parenthood? ____Yes ____No Code Name: __________________

In case of emergency, whom should we contact? Name: ____________________

Phone: ___________ Relationship: ___________ Does this person know you are here today? ___Yes ___No

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List any medications currently taking: ____________________

List know drug allergies: ____________________

List any medical problems under physician's care: ____________________

Where do you usually obtain health care? ____________________

Date last pelvic exam: _______________ Date last Pap smear: ________________ Result: ______________

Do you smoke? ____Yes ____No If yes, how much? ____________________

Do you currently use drugs? ____Yes ____No If yes, describe: ____________________

Do you drink alcohol? ____Yes ____No If yes, describe: ____________________

Have you used any alcohol or drugs in the last twenty-four hours ? ____ Yes ____ No

What time did you last have something to eat or drink? ____________________

How did you hear about Planned Parenthood of North Texas? ____________________

List any past surgery(ies) (include C-section): ____________________

List any other hospitalizations (including delivery dates): ____________________

List any disability: ____________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Check Yes or No)

Yes	No		Yes	No	
___	___	Abnormal Pap smear. Result: _____	___	___	Intestinal problems (ulcer/colitis)
___	___	Cryosurgery/conization/LEEP	___	___	Rubella (German measles)
___	___	Laparoscopy	___	___	Dizzy/fainting spells
___	___	Pelvic Inflammatory Disease (PID)	___	___	Depression/psychatric care
___	___	Chlamydia	___	___	Blurred double vision
___	___	Gonorrhea	___	___	High blood pressure
___	___	Syphilis	___	___	Heart murmur/heart disease/bacterial endocarditis
___	___	Herpes	___	___	Chest pains, shortness of breath, arrythemias
___	___	Genital warts (condyloma)	___	___	Diabetes (sugar)
___	___	HIV	___	___	Asthma/lung disease/TB (tuberculosis)
___	___	Breast mass/breast surgery	___	___	Pulmonary embolism
___	___	Ovarian cyst	___	___	Hepatitis/Mononucleosis/liver disease
___	___	Uterine fibroid/other abnormality	___	___	Anemia: type___________
___	___	Sleep apnea	___	___	Frequent severe headache/migraine
___	___	Thyroid problems	___	___	Stroke or heart attack
___	___	Kidney disease	___	___	Blood clots/phlebitis
___	___	Urinary tract infections	___	___	Bleeding/clotting disorder
___	___	Gall bladder disease	___	___	Lupus
___	___	Cancer: type _________________	___	___	Numbness/paralysis
___	___	Sickle cell anemia	___	___	High cholesterol/triglycerides
___	___	Blood transfusion; date: ________	___	___	IV drug use
___	___	Seizures or convulsions			

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DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? (Check Yes or No)

Yes	No		Yes	No	
___	___	Vaginal bleeding	___	___	Pain with intercourse
___	___	Burning/pain with urination	___	___	Abdominal pain
___	___	Unusual vaginal discharge	___	___	Spotting/bleeding after intercourse
___	___	Growth/sores in genital area	___	___	Fever/chills

Are you adopted? ____Yes ____No Do you know your families medical history? ____Yes ____No
Did your mother, maternal grandmother, or maternal aunt(s) have breast cancer? ____Yes ____No
Did your mother take DES during pregnancy? ____Yes ____No
Have you or your parents, brother(s), sister(s) had: (Check Yes or No.)

Yes	No		Yes	No	
___	___	Heart attack (age___ died? ___)	___	___	Stroke/paralysis
___	___	High cholesterol/triglycerides	___	___	Cancer (type: ___________)
___	___	Diabetes	___	___	Sickle cell anemia
___	___	High blood pressure	___	___	Genetic problems (Tay-Sachs, PKU)

First day of last period: __________________ Age periods began: ________________
Was last period normal? ____Yes ____No If no, explain: ____
How often do you have periods? ___________ Number of days of flow: ____________
Amount of bleeding: ____Light ____Moderate ____Heavy Do you have cramps with period? ____Yes ____No
Premenstrual tension? ____Yes ____No Bleeding/spotting between periods? ____Yes ____No

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Have you had any vaginal bleeding/spotting recently? _____ Yes ______ No
If yes, When? ________________________________ How much? ________________________________
Number pregnancies: _____ Number abortions: _____ Number stillbirths: _____ Number C-sections: _____
Number live births: _____ Number premature: _____ Number miscarriages: _____
Are you currently breast feeding? ____Yes ____No Ages of children: ______________________________
Any problems with deliveries? ____Yes ____No If yes, explain: ______________________________
History of hydatidiform mole pregnancy? _____ Yes _____ No
Do you want to see your ultrasound? ____ Yes ____ No
If your ultrasound today reveals your pregnancy is a multiple pregnancy, do you want to be informed? ____ Yes ___ No

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Current methods of birth control: _______________ How long? ___________ Any problems? ___________
Do you wish to change methods? ____Yes ____No What other methods interest you? _
Have you had a new sexual partner(s) within the past six months? ____Yes ____No
Do you currently have more than one sexual partner? ____Yes ____No

All Patients 16 And Younger Must Complete The Following Section:
Planned Parenthood of North Texas is required to report to local law enforcement any patient under the age of 17 who is sexually active with a partner who is **more than three years older** than the patient. Therefore we are required to ask you the ages of your past and current partners. Please list the ages of your past and current partners: _____ _____ _____ _____ _____ _____

Dealing with personal issues alone or with others can be difficult. If you would like to discuss concerns regarding communications with your partner, parents, or someone else, please let us know.

I certify that I have reviewed and updated my medical, gynecological, family, pregnancy and contraceptive histories and that they are correct to the best of my knowledge. I understand that any deletion or misrepresentation of said histories may have an adverse effect upon my health and agree to release Planned Parenthood of North Texas, Inc. of any and all liability resulting from any and all adverse consequences to my health due to such deletions or misrepresentations.

Patient's Signature: ____ Date: ____________________

History reviewed by (Staff): ______________________________________ Date: ____________________
Title: ____

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