Planned Parenthood®
Southwest Ohio Region

INITIAL HISTORY

Date:_____ Center:_____ List your allergies (medicines, latex):_____
Name:_____ _____
Chart Number:_____ _____
Date of Birth:_____ Age:_____
List any medicines you are taking now (including over-the-counter/alternative drugs):_____
_____

Yes No
☐ ☐ Are you receiving medical care with another health provider?
Name:_____
Reason for visit today:_____
_____
_____
☐ ☐ Have you been hospitalized in the past year?
If yes, why?_____
_____

MENSTRUAL/GYN HISTORY

Age when period started:_____
Periods are: ☐ Regular ☐ Irregular ☐ Painful
Flow is: ☐ Light ☐ Moderate ☐ Heavy
On the heaviest day, how many tampons or pads do you use?__
Periods come every _____ days. Bleeding lasts _____ days.
Do you bleed between periods? ☐ Yes ☐ No
First day of your last period:_____
Was it normal? ☐ Yes ☐ No

Yes No
☐ ☐ Previous pelvic exam? Date:_____
☐ ☐ Pap smear? Date:_____
Normal? ☐ Yes ☐ No
☐ ☐ Previous mammogram? Date:_____
Normal? ☐ Yes ☐ No

Have you or do you have any of the following?
(check all that apply)

☐ Chlamydia ☐ Warts/HPV ☐ Severe PMS
☐ Gonorrhea ☐ PID ☐ Breast Cancer
☐ Trichomonas ☐ Endometriosis ☐ Other Cancer
☐ Hepatitis B or C ☐ Fibroids ☐ Herpes
☐ HIV/AIDS ☐ Abnormal pap smear
☐ Treatment for an abnormal pap/LEEP/Laser or cone of cervix
☐ Other
Dates of treatment:_____

PREGNANCY HISTORY

☐ If never pregnant, please skip this section

Number of Live Births ____ Date(s)_____
Number of C-Sections ____ Date(s)_____
Number of Premature Births ____ Date(s)_____
Number of Miscarriages ____ Date(s)_____
Number of Still Births ____ Date(s)_____
Number of Ectopics (tubal) ____ Date(s)_____
Number of Abortions ____ Date(s)_____
Number of Living Children ____ Age(s)_____
Number of children placed for Adoption _____

Have you had any of the following problems with a pregnancy:
☐ Gestational diabetes ☐ Preterm Labor
☐ High blood pressure or "toxemia"
☐ Genetic abnormalities ☐ Other _____

Are you breastfeeding now? ☐ Yes ☐ No

CONTRACEPTIVE HISTORY

Now	Past		Now	Past	
☐	☐	Pill _____ (Brand)	☐	☐	Diaphragm
☐	☐	Depo Provera (shot)	☐	☐	Tubal
☐	☐	Nuva (The Ring)	☐	☐	Vasectomy
☐	☐	Condom	☐	☐	Rhythm/Natural
☐	☐	Withdrawal	☐	☐	Implanon
☐	☐	Evra (The Patch)	☐	☐	Lea Shield
☐	☐	Abstinence	☐	☐	Female condom
☐	☐	Essure	☐	☐	Foam/Sponge/Film
☐	☐	IUD _____ (Brand) Exp: _____			
☐	☐	Norplant _____ (Expiration)			

Comments or problems with method(s):_____
_____
Do you want a method today? ☐ Yes ☐ No
If yes, what?_____

SURGICAL HISTORY

Yes	No		Date(s)
☐	☐	Hysterectomy (Abdominal/Vaginal)	_____
☐	☐	Tubal ligation	_____
☐	☐	D & C	_____
☐	☐	Ovaries removed (Left/Right)	_____
☐	☐	Bladder surgery	_____
☐	☐	Gallbladder removed	_____
☐	☐	Breast surgery	_____
☐	☐	Appendectomy	_____
☐	☐	Laparoscope	_____
☐	☐	Laser *(if yes, what?)*	_____
☐	☐	Other _____	_____

PAST MEDICAL HISTORY

Have you ever had any of the following?

Yes	No		
☐	☐	Cancer *(what type?)*	_____
☐	☐	Anemia	_____
☐	☐	Eating disorder	_____
☐	☐	Sickle cell anemia	_____
☐	☐	Genetic condition *(what?)*	_____
☐	☐	Severe depression	_____
☐	☐	Vaccine for Rubella/MMR	_____
☐	☐	Seizures/Epilepsy	_____
☐	☐	Liver disease/Hepatitis/Jaundice	_____
☐	☐	Mono	_____
☐	☐	Gallbladder disease/Surgery	_____
☐	☐	Asthma	_____
☐	☐	Heart murmur/MVP	_____
☐	☐	Hemorrhage or Clotting disorder	_____
☐	☐	Bladder/Kidney problems	_____
☐	☐	Breast lump/Surgery	_____
☐	☐	Chronic adrenal failure or steroid use (Addison's Disease)	_____
☐	☐	Blood transfusion(s) prior to 1985	

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NAME:_____ CHART NUMBER:_____

FAMILY/PERSONAL MEDICAL HISTORY

Yes	No		
☐	☐	Are you adopted?	
☐	☐	Did your mother take DES while she was pregnant with you? *(if you were born before 1971)* Mother's age _____ OR died at age _____ Father's age _____ OR died at age _____	

Do you (Me), your Mother (M), Father (F), Sister (S), Brother (B) have any of the following?

Yes	No		Who
☐	☐	High Cholesterol	_____
☐	☐	Diabetes	_____
☐	☐	High Blood Pressure	_____
☐	☐	Cancer	
		Breast	_____
		Uterine	_____
		Ovarian	_____
		Colon or Bowel	_____
☐	☐	Heart disease/attack	_____
☐	☐	Stroke	_____
☐	☐	Osteoporosis	_____
☐	☐	Thyroid or glandular disease	_____
☐	☐	History of blood clots in legs or lungs	_____
☐	☐	Disabilities If yes, please describe.	_____

SOCIAL HISTORY

Yes	No					
☐	☐	Sexually Active	☐ Vaginal	☐ Oral	☐ Anal	
☐	☐	Sexual Partner(s)	☐ Male	☐ Female	☐ Both	
		Age at first intercourse:_____				
☐	☐	More than one sex partner in last year or change in partner?				
☐	☐	Current sex partner has more than one partner?				
☐	☐	Sex since last menstrual period				
☐	☐	Does your partner have signs of an infection?				
☐	☐	Have any of your male partners had sex with men?				
☐	☐	Have any of your partners used IV drugs?				
☐	☐	Request testing for sexually transmitted infections				
☐	☐	Emotional/relationship problems you would like to discuss				
☐	☐	Someone hits, slaps, kicks, hurts you or forces you to have sex				
☐	☐	Afraid of your partner(s) or others				

If you are under eighteen (18) and answered yes, we are required to report abuse to the proper authorities

HEALTH HABITS

(check or fill in blanks to all that apply)

Occupation _____

Yes	No		Yes	No	
☐	☐	Exercise *(type)*:_____	☐	☐	Do self-breast exam
☐	☐	Calcium supplement	☐	☐	Wear seat belts
☐	☐	Street drugs *(type)*:_____			
☐	☐	Drink alcohol # of drinks per week?_____			
☐	☐	Smoke cigarettes # of cigarettes per day?_____			
☐	☐	Does alcohol and/or drugs cause problems in your life?			
☐	☐	Exposed to chemical hazards at place of employment?			

REVIEW OF SYSTEMS

*Check all that are a problem **now***

Yes	No		
☐	☐	Urinary incontinence/Leakage of urine	_____
☐	☐	Sexual problems *(change in sex drive or pain)*	_____
☐	☐	Vaginal discharge with itching/burning	_____
☐	☐	Unusual Fatigue	_____
☐	☐	Unusual Weakness	_____
☐	☐	Abnormal Thirst	_____
☐	☐	Skin Trouble	_____
☐	☐	Swollen Glands	_____
☐	☐	Arthritis, Joint Pain	_____
☐	☐	Varicose Veins	_____
☐	☐	Cramps in Legs	_____
☐	☐	Breast: Lump/Discharge/Pain	_____
☐	☐	Chronic Cough	_____
☐	☐	Shortness of Breath	_____
☐	☐	Night Sweats	_____
☐	☐	Chest Pain or Pressure	_____
☐	☐	Palpitations or Fluttering of heart	_____
☐	☐	Swollen Ankles	_____
☐	☐	Loss of Appetite	_____
☐	☐	Trouble Swallowing	_____
☐	☐	Nausea or Vomiting	_____
☐	☐	Pain in Abdomen	_____
☐	☐	Constipation	_____
☐	☐	Diarrhea/Bloody Stools	_____
☐	☐	Neck: Lump/Pain or Stiffness	_____
☐	☐	Frequent Headaches	_____
☐	☐	Fainting Spells/Dizzy Spells	_____
☐	☐	Convulsions	_____
☐	☐	Depression or Anxiety	_____
☐	☐	Sleep Difficulty	_____

STAFF NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature:_____ Date:_____

Practitioner Signature:_____

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