Planned Parenthood of Montana

HEALTH HISTORY

YES	NO	SOCIAL HISTORY
		Have you ever used tobacco?
		Are you currently using tobacco? If yes, how many cans/wk or cigs/day_____
		Do you drink alcohol? If yes, how many drinks/day_____
		Any drug use/abuse (prescription and/or street drugs)
		History of physical, sexual or emotional abuse ❑ as a child ❑ as an adult
		Are you afraid of your partner, a family member or someone else important to you?
		Would you like to discuss issues concerning unhealthy relationships and/or abuse?
		Have you been hit, slapped, kicked or otherwise physically abused by someone?
		Have you been verbally threatened or made to feel afraid?
		Has anyone forced you to have sexual activities that made you feel uncomfortable?
		Have you ever been abused by your intimate partner?
		Has your partner tampered with your birth control, refused to wear condoms or pressured you to become pregnant?
		Are you afraid your partner will hurt you if you say you have an STI and your partner needs to be treated?

STI / HIV RISK ASSESSMENT

Are you currently in a sexual relationship? ❑Yes ❑No
How long have you been with this partner? _____
Do you have other partners? ❑Yes ❑No How many? _____
# of partners last 3 mos_____ # of partners last 12 mos_____
Number of partners in your lifetime: _____
Age of first intercourse_____
Date of last intercourse/last sexually active: _____
Have you had sex without birth control or protection in the past month?
❑Yes ❑No When:_____

Do you have sex with:
❑Men ❑Women ❑ Both ❑Other:_____

Do your sexual practices include: ❑Vaginal ❑Oral ❑Anal

Do you use condoms with sex partner(s)?
❑ always ❑usually ❑sometimes ❑never ❑not applicable

History of sexually transmitted infection: ❑Chlamydia ❑Gonorrhea
❑Genital Warts ❑HIV ❑Hepatitis (A,B,C) ❑Herpes ❑Syphilis ❑PID
❑Trichomoniasis ❑None ❑Don't Know
❑Other:_____

YES	NO	
		Have you or your partners ever used needles to inject drugs?
		Have you or your partners ever exchanged sex for drugs or money?
		Has your partner had sex with someone other than you in the past year?

Does your partner have sex with:
❑Men ❑Women ❑ Both ❑Other:_____

YES	NO	BIRTH CONTROL USE
		Are you or your partner using a birth control method now? If yes, which one? _____ How long have you used it? _____
		Any problems with this method? If yes, what? _____
		Do you want to change your birth control?
		What birth control methods have you or your partners used in the past:

GENDER IDENTITY (If applicable)

Sex assigned at birth/biological sex: ❑Female ❑Male

Current gender identity: ❑Female ❑Male
❑Gender non-conforming ❑Other:

Preferred pronouns: ❑ she, her, hers ❑ he, him, his ❑ ze, hir
❑ they, them, theirs ❑ Other:

Preferred name (if different than legal name):

Have you had any gender affirming surgeries? ❑Yes ❑No
Please list:

YES	NO	PREGNANCY HISTORY (If applicable)
		Have you ever been pregnant?
		Do you want to get pregnant in the future? If yes, ❑In the next year ❑not for a while ❑don't know
		Are you breastfeeding?
		_____Total # of Pregnancies Date of Last Delivery: _____Number of live births _____ _____Number of Abortions _____Number of Miscarriages Date of Last Abortion: _____# of Tubal Pregnancies _____
		Any C-sections?
		Any complications?

MENSTRUAL HISTORY (If applicable)

Age at first period? _____
Do you get a period every month? ❑Yes ❑No How often_____
Do you have problems with:
❑ cramps ❑ bloating ❑ emotional changes ❑ heavy bleeding

Are you planning surgery that will keep you in bed for a long time?
❑Yes ❑No

NAME _____ DOB: _____ Chart#: _____

Planned Parenthood of Montana

HEALTH HISTORY

MEDICATIONS	**ALLERGIES**
Are you taking any medications? (vitamins, herbs, over -the -counter and prescription) If yes, which ones?	Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, please list:

PERSONAL MEDICAL HISTORY. Please check any condition listed below that you personally have ever had: (If applicable:)

❑ Anemia	❑ Hernia	❑ Abnormal undiagnosed vaginal bleeding
❑ Anxiety	❑ High blood pressure (Hypertension)	❑Breast lump or mass
❑ Arthritis	❑ Irritable bowel disease	❑ Breast or ovarian cancer
❑ Asthma	❑ Kidney problems (Renal disease)	Other breast conditions:
❑ Birth defects or genetic problems	❑ Liver problems (Hepatitis, liver disease,	❑ Lobular carcinoma in situ (LCIS) of the
❑ Blood clots, clotting disorder	tumor, etc.)	breast
❑ Bruising/bleeding disorder	❑ Lupus	❑ Atypical hyperplasia of the breast
❑ Cancer. If yes, what type, when?	❑ Neurological problems (brain tumor,	❑ Chest radiation for treatment of disease
❑ High cholesterol (Elevated lipids)	meningioma, etc.)	❑ Diabetes during pregnancy
❑ Depression	❑ Osteoporosis	❑ Endometriosis
❑ Diabetes Age at diagnosis_____	❑ Seizures/epilepsy (Seizure disorder)	❑ Fibroids (fibroid uterus)
❑ Eating disorder (anorexia, bulimia)	❑ Sickle cell disease/trait	❑ Gestational trophoblastic disease (molar
❑ Eye or hearing problems	❑ Skin problems	pregnancy)
❑ Gallbladder problems	❑ Stroke or stroke like problems	❑ Problems with IUC/IUD
❑ Gout	❑ Stomach problems	❑ Ovarian cysts
❑ Bad headaches/migraine headaches	❑ Thyroid problems	❑ Pelvic infection (actinomycosis, PID, other)
❑ Heart attack (Myocardial infarction)	❑ Tuberculosis or exposure to tuberculosis	❑ Polycystic ovary syndrome
❑ Heart disease	❑ Wilson's disease, problems with copper	❑ Toxic shock syndrome
❑ Heart valve problem	❑ Did your mother take DES when she was	❑ Uterine problems (abnormal shape, size,
❑ Heart murmur	pregnant with you?	other)

❑ Headaches with visual changes, numbness/tingling, and/or speech problems

Any other medical or psychological problem(s):

HOSPITALIZATIONS

Check if you have ever had:	List any hospitalizations you have had and why:
❑ Weight loss surgery ❑ Organ transplant	

If your last Pap and/or a mammogram was somewhere else, please write in the date ❑ Not applicable

Date of last Pap_____ Date of last Mammogram:_____

Have you ever had a Pap that was not normal? ❑yes ❑no

FAMILY HISTORY. Please check any condition below that any family members or close relatives have had:

❑ Blood clotting disorders	❑ Genetic problems
❑ Breast or ovarian cancer	❑ High blood cholesterol or fats
❑ Other cancer (colon, skin)	❑ High blood pressure (Hypertension)
❑ Heart attack before age 65	❑ Stroke before age 65
❑ Diabetes	❑ Thyroid problems

IMMUNIZATIONS. Please check any immunizations you have had:

❑ MMR Immunization	Date: _____	(List dates if known)
❑ Hepatitis B Immunization	Date: _____	
❑ HPV Gardasil Immunization	Date: _____	
❑ Tetanus Immunization	Date: _____	

Current symptoms. Are you experiencing any of these symptoms NOW: (If applicable:)

❒Chills	❒ Chest pain	❒ Blood in urine	❒ Anxiety	❒ Painful periods
❒ Fatigue	❒ Abdominal pain	❒ Urinary frequency	❒ Depression	❒ Hot flashes
❒ Fever	❒ Nausea	❒ Leaking urine	❒ Cold intolerance	❒ Irregular periods
❒ Weight gain	❒ Vomiting	❒ Genital discharge	❒ Heat intolerance	❒ Vaginal discharge
❒ Weight loss	❒ Blood in stools	❒ Pain with sex	❒ Joint pain	❒ Bleeding after sex
❒ Hearing loss	❒ Change in stools	❒ Mole changes	❒ Leg pain or swelling	❒ Breast discharge
❒ Visual changes	❒ Constipation	❒ Rash	❒ Easy bleeding	❒ Breast lump
❒ Chronic cough	❒ Diarrhea	❒ Extremity numbness	❒ Easy bruising	❒ Breast pain
❒ Shortness of breath	❒ Jaundice	❒ Headache	❒ Swollen glands	
❒ Wheezing	❒ Painful urination			

NAME _____ DOB: _____ Chart#: _____