Comprehensive Family Planning History - Female

Patient Identification:

Today's date: _____
Birth date: _____ Age: _____
List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: _____

Family History

Yes	No	Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.
☐	☐	Blood clots in arms/legs/chest_____
☐	☐	Bleeding problems _____
☐	☐	High blood pressure_____
☐	☐	High cholesterol/triglycerides_____
☐	☐	Breast/ovarian/uterine/colon cancer _____
☐	☐	Heart attack_____
☐	☐	Stroke_____
☐	☐	Diabetes_____
☐	☐	Birth defects_____
☐	☐	Alcohol/drug abuse

Menstrual History

Date of the first day of your last menstrual period: _____

Yes	No	
☐	☐	Was your last menstrual period normal? If not, explain: _____
☐	☐	Do you have a period every month? Is the flow: ___light ___ medium ___ heavy
☐	☐	Do you bleed between periods?
☐	☐	Do you have cramps with your periods?
☐	☐	Do you take medication for cramps? ☐ Over the counter or ☐ Prescription medication? How old were you when you had your first period? _____

Your Birth Control History

Yes	No	
☐	☐	Are you using a method of birth control now? If yes, what method?_____
☐	☐	Have you used any birth control methods that you have had a problem with? What method/s?_____
☐	☐	In the last 5 days or since your last period, have you had sex without birth control? (condoms are birth control)

Your Medical History

Yes	No	Do you have now or have you had any of the following?
☐	☐	Are you taking any prescription or over the counter medicines now? Please list: _____
☐	☐	Asthma
☐	☐	Heart disease, high blood pressure
☐	☐	Blood clots in arms/legs/chest
☐	☐	Heart attack or stroke
☐	☐	High cholesterol/triglycerides
☐	☐	Migraines or frequent headaches
☐	☐	Visual changes or numbness
☐	☐	Lupus (SLE)
☐	☐	Cancer: What type? _____When?_____
☐	☐	Blood problems (Sickle cell anemia, hemophilia, low iron)
☐	☐	Have you or your partner ever had a blood transfusion, tissue/organ transplant or artificial insemination?
☐	☐	Inflammatory bowel disease (IBD)
☐	☐	Gall bladder disease
☐	☐	Surgery - List type and date _____
☐	☐	Thyroid problems
☐	☐	Breast disease
☐	☐	Mammogram - Date _____
☐	☐	Kidney or bladder problems
☐	☐	Liver disease (hepatitis, mono, jaundice, cirrhosis)
☐	☐	Diabetes
☐	☐	Epilepsy or convulsions
☐	☐	Depression or emotional problems

Immunization History (list date(s))

☐	☐	Measles, mumps, rubella (MMR) vaccine _____
☐	☐	Tetanus, diphtheria, pertussis (Td/Tdap)vaccine _____
☐	☐	Hepatitis A vaccine_____
☐	☐	Hepatitis B vaccine _____
☐	☐	Varicella (chicken pox) vaccine_____
☐	☐	HPV (human papilloma virus) vaccine_____
☐	☐	Flu vaccine_____

Over

Your Pregnancy History

How many times have you been pregnant? _____

List the dates that you have had a baby: _____, _____

_____, _____, _____, _____,_____

How many living children do you have? _____

List the dates of any miscarriages or abortions: _____

_____

List the dates of any tubal pregnancies: _____

Are you breast-feeding now? Yes _____ No _____

Yes	No	
☐	☐	Have you had a baby that weighed less than 5 1/2 pounds?_____
☐	☐	Have you had a baby that weighed more than 9 pounds?_____
☐	☐	During any pregnancy did you have high blood pressure, diabetes, or a baby with birth defects?_____

Do you plan a pregnancy in the future? No / Yes When_____

Your Gynecological History

*****When was your last Pap test done?** _____

Yes	No	**Have you ever had any of the following?**
☐	☐	Abnormal Pap test If yes, When? _____
☐	☐	Colposcopy or treatment of your cervix (When?)_____
☐	☐	Ovary problems
☐	☐	Uterus problems or Uterine fibroids
☐	☐	Pelvic Inflammatory disease (PID)
☐	☐	Genital warts/HPV
☐	☐	Gonorrhea
☐	☐	Chlamydia
☐	☐	Syphilis
☐	☐	Genital herpes
☐	☐	Pain or other problems with sex
☐	☐	Vaginal infections (like yeast or bacterial vaginosis)
☐	☐	If you were born before 1975, did your mother take DES when she was pregnant with you?

_____

Client signature

_____

Staff signature

Your Personal History

Yes	No	
☐	☐	Do you smoke cigarettes? How many cigarettes a day?____ Smokeless tobacco?_____
☐	☐	Do you drink alcohol? How many drinks a day?_____ week?_____
☐	☐	Do you ever feel you should cut down on your drinking?
☐	☐	Are you using any street drugs? (Ecstasy, meth, weed, etc.)
☐	☐	Are you using prescription medication not prescribed for you?
☐	☐	Have you or your sexual partner(s) ever used needles for drugs? (shoot drugs)
☐	☐	Have you or your sexual partner(s) ever exchanged sex for drugs or money?
☐	☐	Have any of your male partners had sex with other men?
☐	☐	Do you use condoms? Never____ Sometimes___ Always_____
☐	☐	Have you had HIV testing? When? _____
☐	☐	Are you HIV positive?
☐	☐	Have you ever been forced to have sex?
☐	☐	Have you ever been hit, slapped, kicked, shaken or hurt by anyone?
☐	☐	Is there anyone who makes you feel unsafe now?
☐	☐	Have you had a new partner in the last 2 months?
☐	☐	Does your sex partner have other partners?

1. How many sexual partners have you had in the last 2 months?___
2. How many sexual partners have you had in the last year? _____
3. Are your sex partner's male _____ female _____ both _____?
4. Do you have oral sex_____ vaginal sex_____ anal sex_____?
5. When was the last time you had sex? _____

Your Nutritional History

Yes	No	
☐	☐	Are there changes you would like to make to your diet? If yes, describe_____
☐	☐	Are you on a special diet? (e.g. vegetarian, diabetic) If yes, please describe _____
☐	☐	Do you exercise regularly? Describe_____
☐	☐	Have you ever vomited or used laxatives to lose weight? When was the last time? _____
☐	☐	Are you taking: __ Vitamins __ Iron __ Folic Acid __ Calcium?

List other supplements, herbs or weight loss preparations you use:

_____

Is your weight: __ just about right __ too heavy __ too thin