

Comprehensive Family Planning History

Your Family History

- Please check here if you don't know your family history.
- Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.**
- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots in arms/legs/chest _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol/triglycerides _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast/ovarian/uterine/colon cancer _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth defects _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/drug abuse _____ |

Your Medical History

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

Patient Identification:

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

Your Personal History

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or use any form of tobacco?
How much per day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? How many drinks a day? _____
Per week? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever feel you should cut down on your drinking? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you used marijuana in the past year? |
| <input type="checkbox"/> | <input type="checkbox"/> | In the past year, have you used an illegal drug or a prescription drug for non-medical reasons? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hit, slapped, kicked, shaken or hurt by anyone? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there anyone who makes you feel unsafe now? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been forced to have sex? |

Your Nutritional History

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are there changes you would like to make to your diet? If yes, describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise regularly? Describe: _____ |

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

Immunizations (list date(s))

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Measles, mumps, rubella (MMR) vaccine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus, diphtheria, pertussis (Td/Tdap) vaccine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A vaccine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B vaccine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicella (chicken pox) vaccine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HPV (human papilloma virus) vaccine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Flu vaccine _____ |

Comprehensive Family Planning History

Your Sexual/ Reproductive Health

Have you ever had any of the following sexually transmitted infections:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia |
| <input type="checkbox"/> | <input type="checkbox"/> | Syphilis |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital warts/Human Papilloma Virus or HPV |
| <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Trichomoniasis |
| <input type="checkbox"/> | <input type="checkbox"/> | Non-gonorrheal urethritis |
|
 |
 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you or your sexual partner(s) ever used needles for drugs (to shoot drugs)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you or your sexual partner(s) ever exchanged sex for drugs or money? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use condoms?
Never ___ Sometimes ___ Always ___ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had HIV testing? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you HIV positive? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a new partner in the past 2 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your sex partner have other partners? |

1. How many sexual partners have you had in the past 2 months? ___
2. How many sexual partners have you had in the past year? ___
3. Are your sex partners: male ___ female ___ both ___
transman ___ transwoman ___ Intersex ___ Other ___
4. Do you have: oral sex ___ vaginal sex ___ anal sex ___?
5. When was the last time you had sex? _____
6. Have any of your male partners had sex with other men?
Yes ___ No ___ N/A ___

(Male / Assigned male at birth/ MTF)

Your Urological History

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have abnormal discharge from the penis now?
Describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have now or in the past a lesion, sore, or lump on your penis?
Describe: _____ When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have now or had in the past a lesion, sore, or lump on your scrotum or testicles?
Describe: _____
When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had pain during sex?
When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had gender affirming surgery? If so, describe:
_____ |

Your Reproductive History

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | How many children do you have? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you want children in the future? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you using birth control?
Please check the birth control method(s) you use: <input type="checkbox"/> Condoms <input type="checkbox"/> Vasectomy
<input type="checkbox"/> Rely on partner's method. What method does your partner use? _____ |

(Female / Assigned female at birth/ FTM)

Do you want to become pregnant in the next year? Yes ___ No ___

Menstrual History

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

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Was your last menstrual period normal?
If not, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a period every month?
Is the flow: ___light ___ medium ___ heavy |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you bleed between periods? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have cramps with your periods? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take medication for cramps?
<input type="checkbox"/> Over the counter
<input type="checkbox"/> Prescription medication |
| | | How old were you when you had your first period? ___ |

Your Pregnancy History

How many times have you been pregnant? _____

List the dates that you gave birth: _____

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 | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a baby that weighed less than 5 1/2 pounds? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a baby that weighed more than 9 pounds? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | During any pregnancy did you have high blood pressure, diabetes, or a baby with birth defects? _____ |

Your Gynecological History

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

- | Yes | No | Have you had any of the following? |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Pap test
If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Colposcopy or treatment of your cervix (When?) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ovary problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Uterus problems or uterine fibroids |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvic Inflammatory Disease (PID) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain or other problems with sex |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal infections (yeast or bacterial vaginosis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had gender affirming surgery? If so, describe:
_____ |

Your Birth Control History

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