

## FEMALE FAMILY PLANNING HEALTH HISTORY FORM

*Please answer the questions below:*

Last Name:	First	Date of birth	Age	Date today
Home phone number ( )	Message/pager number ( )		Best time to call	

What is the main reason for your visit today? \_\_\_\_\_

Are you allergic to any medicines, shellfish, or copper? <i>Which ones and describe what happened:</i>	<b>NO</b>	<b>YES</b>
	<input type="checkbox"/>	<input type="checkbox"/>
Do you take (or are you supposed to take) medicines, natural remedies, aspirin, or other drugs every day? <i>List them:</i>	<input type="checkbox"/>	<input type="checkbox"/>

NO	YES	Have you ever had or do you have:	NO	YES
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart attacks or strokes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood clot in your blood vessels like the leg or lung	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (turned yellow)	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Has anyone in your **IMMEDIATE** family (*mother, father, sister, brother, daughter, son, or if your parents are less than 50 give information about other relatives*) had any of the following:

	NO	YES	DO NOT WRITE HERE
Cancer: Who, what type and at what age found?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes: Who and at what age?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack: Who and at what age?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke: Who and at what age?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood clots in blood vessels like the leg or lung? Who and at what age?	<input type="checkbox"/>	<input type="checkbox"/>	_____

*Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.*

Do you use tobacco? **NO**  **YES**  How much do you use? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcohol? **NO**  **YES**  How often?  daily  weekly  monthly

How many alcoholic drinks do you have at one time?  1-2 drinks  3-4 drinks  5+ drinks

Do you use other drugs (examples: marijuana or cocaine)? **NO**  **YES**

What do you use? \_\_\_\_\_ How often?  daily  weekly  monthly

Do you feel safe from violence in your personal relationships? **YES**  **NO**

Have you ever had a sexually transmitted disease or genital infection? **NO**  **YES**

*Circle the ones you might have had:*

Chlamydia	Gonorrhea	Herpes	Genital Warts	PID	Syphilis
HIV	Bacterial Vaginosis	Trichomonas	Hepatitis B or C	Yeast	

(turn over)

How many different sex partners have you had in the last 12 months? \_\_\_\_\_  
Were your partners (*circle*):                      men                      women                      both

How long have you been with your current sex partner(s)? \_\_\_\_\_

What type of sex have you had in the past 2 months? (*circle the types*)  
Vaginal                      Oral                      Anal                      Other                      No Sex

Do you have symptoms of a genital infection?    **NO**     **YES**  (*circle the ones you have*)  
Discharge                      Odor                      Itch                      Rash  
Bumps                      Sores                      Pain with sex                      Bleeding after sex  
Burning                      Stool or anal problems                      Pain with urination                      Urgent or frequent urination

Have you used a birth control method before?    **NO**     **YES**  (*Circle the types you have used and write in years of use:*)

Pills	Condoms	Diaphragm	Norplant
IUD	Shot/Depo	Vasectomy/Tubal	Abstinence
Withdrawal	Suppository/Film/Foam	Natural Family Planning/Rhythm	Other

What do you use now? \_\_\_\_\_

List any problems with your current methods:

Have you used birth control pills or injections for more than 5 years?    **NO**     **YES**   
(*this can prevent cancer of the ovaries and uterus*)

How old were you when you had your first period?                      Age: \_\_\_\_\_

For your most recent period, what was the first day bleeding started?    Date: \_\_\_\_\_

How many days do your periods last?    # of days: \_\_\_\_\_

How many days from the start of one period until the start of the next period?    # of days: \_\_\_\_\_

When was the last time you had sex with a male without birth control?    Date: \_\_\_\_\_

Do you think you could be pregnant today?    **NO**     **YES**

Do you ever douche or use genital deodorant sprays, powders or wipes?    **NO**     **YES**

Will this be your first pelvic exam today?    **NO**     **YES**     Date of your last Pap test: \_\_\_\_\_

Have your Pap tests been normal?    **YES**     **NO**

If you have had an abnormal Pap test, when, where, and what was done? \_\_\_\_\_

Have you ever been pregnant?    **NO**     **YES**  (*If no, you are done*)

# of pregnancies _____	# of deliveries _____	# of miscarriages _____
# of living children _____	# of abortions _____	

If you have been pregnant before, when did your last pregnancy end?    Date: \_\_\_\_\_

Are you currently breastfeeding?    **NO**     **YES**

When you were pregnant, did you get diabetes?    **NO**     **YES**

Have any of your babies been 10 pounds or more?    **NO**     **YES**      no babies

History reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_