NECAC FAMILY PLANNING CENTER

*Patients Please Supply Updated Information

PATIENT HISTORY SHEET

NAME ______________________ *DATE ____/____/____

BIRTH DATE ____/____/____ *WHO IS YOUR PRIVATE DOCTOR? ______________________

*MAJOR MEDICAL CARE IN THE PAST YEAR ______________________

LAST PAP SMEAR ____________ RESULTS ____________ IS THIS YOUR FIRST PELVIC EXAM? YES_____ NO_____

*MEDICAL HISTORY

*Have you or any blood relatives had any of the following conditions?

YES	NO		SELF	RELATIVE
		Diabetes		
		High Blood Pressure		
		Epilepsy		
		Migraine Headaches		
		Cancer		
		Heart Attack before age 50		
		Genetic problems		
		Maternal exposure to DES		
		High cholesterol		
		Sickle cell anemia		

*Have YOU ever had any of the following conditions?

YES	NO	
		Eating disorders: obesity, anorexia, bulimia
		Frequent or severe headaches
		Heart problems/murmurs or Respiratory/Asthma
		Stomach/intestinal problems
		Mono or liver problems/Hepatitis
		Thyroid problems
		Emotional problems/Depression/Substance abuse
		Vision problems
		Blood clots in veins/varicose veins
		Anemia/Immune Disorders/Lupus
		Breast disease/lump/nipple discharge
		Gall bladder problems/infections
		Kidney/bladder problems/infections
		HIV/gonorrhea/syphilis/herpes, warts & chlamydia
		Uterine growths/fibroids/ovarian cysts
		Infection of uterus, tubes, ovaries
		Abnormal pap smear When:
		Been vaccinated for Measles, Mumps, Rubella
		Domestic Violence/Sexual Abuse (Actual or potential) You/Children
		MEDICATION ALLERGIES, Please list:
		Current medications:
		Do you smoke cigarettes, use street drugs, tobacco or alcohol? If yes, specify amount.

THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

SIGNATURE OF CLIENT ______________________

*HOSPITAL/SURGICAL HISTORY

*YEAR

Breast Surgery ____________

OB-GYN ____________

OTHER SURGERY or MAJOR HOSPITALIZATIONS:

____

____

____

Have you ever had a mammogram? ______

*PREGNANCY HISTORY

No. of pregnancies ____________

No. of live births ____________

No. of living children ____________

No. of miscarriages ____________

No. of stillbirths ____________

No. of induced abortions ____________

No. of tubal pregnancies ____________

No. of premature deliveries ____________

No. of Vaginal deliveries ____________

No. of C-Section deliveries ____________

Your age with first pregnancy ____________

Last delivery date ____________

Complications with any pregnancies i.e., Toxemia, genetic problems, diabetes YES ________ NO ________

If yes, explain ____________

*BIRTH CONTROL PILL USERS

Since your last visit, have you had problems with any of the following:

YES	NO	
		Chest Pain
		Headaches (severe)
		Blurred vision
		Leg pains
		Dizziness
		Shortness of breath
		Depression

*MENSTRUAL HISTORY

First date of last period ____________

Age periods began ____________

How many days between periods ____________

How many days of bleeding ____________

*In the past 2 months, have you had any of the following problems.

YES	NO	
		Menstrual discomfort/cramps
		Pain or burning with urination
		Unusual vaginal discharge
		Vaginal itching, burning, sores,
		Pain/bleeding with intercourse
		Missed periods

*CONTRACEPTIVE HISTORY

Current method of birth control? ____________

Methods of birth control used:

____ Pill

____ IUD

____ Diaphragm

____ Vasectomy

____ Sterilization/Tubal

____ Foam/cream suppository

____ Natural Family Planning

____ Depo Shot

____ Condoms

____ Sponge

____ Withdrawal

____ Norplant

____ Patch

____ NuvaRing

____ Implanon

Problems with any of these methods:

____

What method do you want to use now?

____

*SEXUAL HISTORY

Age of first intercourse ________

Are you currently sexually active?

YES ________ NO ________

Do you think you might be pregnant now?

YES ________ NO ________

Have you had sex without using any method of birth control since your last period?

YES ________ NO ________

***HAVING MORE THAN ONE SEX PARTNER INCREASES THE CHANCE OF SEXUAL DISEASES:**

Have you had more than one sex partner in the past year? YES ________ NO ________

RISK EXPOSURE INFORMATION

YES	NO	
❑	❑	Homo/Bisexual
❑	❑	IV Drug User
❑	❑	Hemophilia
❑	❑	Trade Sex for Drugs
❑	❑	Prostitute
❑	❑	Sex Partner of Homo/Bisexual
❑	❑	Sex Partner of IV Drug User
❑	❑	Sex Partner of PWA/HIV+
❑	❑	Other ____________

Staff Comments: ______________________