

Complete Medical History

Henry County Family Planning

Date _____

FP _____

Name _____
 Address _____
 City _____ State _____ ZIP _____
 Phone _____
 How can we contact you? _____

SSN _____
 Date of Birth _____ Age _____
 Race: Black Hisp Bi-Racial White Indian
 Are you? Married Single Separated Divorced
 Education Level _____
 Student Now? Yes No

Emergency Contact _____ Phone _____

If you live with your parents, are they aware that you are coming to Henry County Family Planning? Yes No

SEXUAL HISTORY

First day of last two periods _____ and _____
 Number of days between periods _____
 Age period started _____
 Describe flow: Heavy Medium Light
 How long do your periods last? _____
 Do you have severe cramps? Yes No
 Are you sexually active? Yes No
 Age at first intercourse? _____
 Lifetime number of sexual partners? _____
 Have you ever had an STD? Yes No
 Have you been tested for HIV? Yes No Date _____
 Result? Positive Negative
 Have you had an abnormal pap? Yes No Date _____
 Did your Mother take DES hormones to prevent a miscarriage? Don't know Yes No
 Do you have sex with: Men Women Both
 Total # of times pregnant? _____
 Date last pregnancy ended _____ How? _____
 _____ # of live births _____ # living now
 _____ # stillborn _____ # abortions
 _____ # miscarriages _____ # ectopic
 Age of your youngest child _____
 Have you ever breastfed? Yes No
 Are you using birth control now? Yes No
 What kind? _____
 Other birth control methods used: (please circle)
 Condom Withdrawal Natural Family Planning
 Patch Pill Depo Nuva Ring
 IUD Diaphragm Sterilization
 Any problems with methods used? Yes No
 Are you planning on having children? Yes No
 If so, when? _____
 Have you had breast disease? Yes No
 Date of your last mammogram? _____

PARTNER SEXUAL HISTORY

Use injectable drugs? Yes No
 Have/had HIV/STDs? Yes No
 Bisexual? Yes No
 Have/had multiple partners? Yes No

SOCIAL HISTORY

Occupation? _____
 Do you smoke? Yes No How much?
 Do you use alcohol? Yes No How much?
 Do you use street drugs? Yes No How much?
 Are/were you abused as a child? Yes No
 Are/were you a victim of domestic violence? Yes No
 Do you exercise? Yes No
 How often? _____ What type? _____
 If you are under 18: Is there an adult with whom you feel comfortable talking about sex? Yes No

REVIEW OF SYMPTOMS

Do you have or had in the past? (Please check if yes)

___ High blood pressure	___ Heart murmur
___ Arrhythmia	___ High cholesterol
___ Blood clots	___ Heart attack
___ Stroke	___ Varicose veins
___ Anemia	___ Blood transfusion
___ Clotting/bleeding disorders	
___ Epilepsy	___ Mental illness
___ Depression	___ Thyroid problems
___ Severe headaches	___ Numbness
___ Vision changes	___ Mono
___ Colitis	___ Stomach problems/ulcers
___ Diabetes	___ Anorexia/Bulimia
___ Hepatitis	___ Gallbladder problems
___ Cystic fibrosis	___ Kidney or bladder problems
___ Allergies	___ Asthma/bronchitis/emphysema
___ Difficulty breathing	___ Genetic problems/birth defects
___ Other	___ Bone problems/disorders

Is anything causing you stress right now? Yes No
 Do you have/ever had cancer? Yes No
 Explain: _____
 Are you taking medications now? Yes No
 List: _____
 Are your immunizations up-to-date? Yes No
 List all surgeries/hospitalizations: _____
 Allergies to food/medications: _____

Complete Medical History (continued)

Henry County Family Planning

PERSONAL NUTRITIONAL INFORMATION

How many servings do you eat of the following every day:

Milk, cheese, other dairy products _____ # of servings/day
 Chips, cakes, pies _____ # of servings/day
 Meat, fish, poultry, eggs or beans _____ # of servings/day
 Fruits and vegetables _____ # of servings/day
 Bread, cereals, grains _____ # of servings/day
 Caffeine (coffee, tea, pop, chocolate) _____ # of servings/day

Other supplements, herbs or weight loss preparations: _____

Please answer the following questions:

How often do you skip meals? _____

Is your weight? Just about right Too heavy Too thin

Have you ever vomited or used laxatives to lose weight?

Yes No When was the last time? _____

Are you on a special diet (e.g., vegetarian, diabetic)?

Yes No If yes, please describe _____

Are you taking:

Vitamins Iron Folic Acid Calcium

Staff Assessment: Adequate Inadequate Comments: _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Respiratory Illness	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Epilepsy/Convulsions	_____	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Liver/intestinal	_____	_____	_____	_____	_____	_____
Death before age 50	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Pregnancy/PP complications	_____	_____	_____	_____	_____	_____
Birth Defects	_____	_____	_____	_____	_____	_____

Do you want a copy of your test results sent to your family doctor? Yes No

Family Doctor Name _____

Address _____

Phone Number _____

How do you want Henry County Family Planning to contact you?

Any Method Plain Envelope Home Phone Work Phone Cell Phone

Can we leave a message? Yes No

All the information you give is confidential.
 To the best of my knowledge the above information is complete and accurate.

 Patient Signature

 Date

 Reviewer Signature