Planned Parenthood of Delaware

Female Medical History

MEDICAL / FAMILY / IMMUNIZATION HISTORY

Allergies

Yes	No	
❑	❑	Are you allergic to any drugs, medicines, or latex?
		If yes, what and what is the reaction?

Current Medications

Yes	No	
❑	❑	Did you take any medication (prescription, over the counter, vitamins, herbs, etc.)?
		If yes, list medication and doses:

Past Medical History

Have you ever had: (please ✓ Yes or No):

Yes	No		Yes	No	
❑	❑	Abnormal PAP	❑	❑	Hepatitis B
❑	❑	Anemia	❑	❑	HIV/AIDS
❑	❑	Asthma	❑	❑	Clotting disorder
❑	❑	Bleeding disorder	❑	❑	High cholesterol
❑	❑	Blood transfusion	❑	❑	High blood pressure**
❑	❑	Breast lump**	❑	❑	Infertility
❑	❑	Cancer, breast	❑	❑	Crohn's/colitis/ constipation
❑	❑	Unusual cells in breast lobes	❑	❑	Kidney failure
❑	❑	Pre-cancerous condition of breast	❑	❑	Liver disease/tumor /hepatitis
❑	❑	Radiation for lung cancer	❑	❑	Lupus
❑	❑	Cancer, cervical	❑	❑	Migraine**
❑	❑	Cancer, other	❑	❑	Heart Attack
❑	❑	Cancer, ovarian	❑	❑	Osteoporosis
❑	❑	Cancer, uterine	❑	❑	Pelvic Inflammatory Disease
❑	❑	Stroke	❑	❑	Polycystic Ovaries/ Ovarian Cyst
❑	❑	Chlamydia	❑	❑	Psychiatric disorder
❑	❑	Blood clot in leg**	❑	❑	Blood clot in lungs
❑	❑	Depression	❑	❑	Seizure/Epilepsy
❑	❑	Receive DES (1940-1971)	❑	❑	Suicide attempt
❑	❑	Diabetes	❑	❑	Syphilis
❑	❑	Drug/alcohol abuse	❑	❑	Thyroid disease
❑	❑	Eating disorder	❑	❑	Tuberculosis
❑	❑	Endometreosis	❑	❑	UTI, recurrent
❑	❑	Fibroid Uterus	❑	❑	Vaginitis, recurrent
❑	❑	Broken bone	❑	❑	Valvular heart disease
❑	❑	Gallbladder Disease	❑	❑	Problems with vaginal muscles
❑	❑	Genital herpes	❑	❑	Hepatitis C
❑	❑	Genital warts	❑	❑	Trichomonias
❑	❑	Kidney stones	❑	❑	Other_____
❑	❑	Gonorrhea			_____
❑	❑	Heart failure			

Past Surgical History

Do you or have you ever had?			Year
Yes	No		
❑	❑	Appendectomy	_____
❑	❑	Breast Implants	_____
❑	❑	Tubal ligation/sterilization**	_____
❑	❑	Breast biopsy	_____
❑	❑	Cesarean section	_____
❑	❑	Gallbladder removed	_____
❑	❑	D and C	_____
❑	❑	Gastric bypass	_____
❑	❑	Heart surgery	_____
❑	❑	Hernia repair	_____
❑	❑	Hysterectomy**	_____
❑	❑	Liver biopsy	_____
❑	❑	Mastectomy – one breast	_____
❑	❑	Mastectomy – both breast	_____
❑	❑	Breast reduction	_____
❑	❑	Removal of fallopian tubes or ovaries	_____
❑	❑	OTHER_____	_____
❑	❑	OTHER_____	_____

Diagnostics History

Have you ever had any of the following tests done?

Yes	No		Normal?	Abnormal?	Date
❑	❑	Biopsy, breast**	❑	❑	_____
❑	❑	Biopsy, endometrial	❑	❑	_____
❑	❑	Biopsy, vaginal	❑	❑	_____
❑	❑	Biopsy, vulvar	❑	❑	_____
❑	❑	Colonoscopy	❑	❑	_____
❑	❑	Colposcopy	❑	❑	_____
❑	❑	Cryosurgery	❑	❑	_____
❑	❑	Laparoscopy	❑	❑	_____
❑	❑	LEEP of cervix, diagnostic	❑	❑	_____
❑	❑	Mammogram, diagnostic	❑	❑	_____
❑	❑	Mammogram, screening**	❑	❑	_____
❑	❑	PAP/HPV**	❑	❑	_____
❑	❑	PPD (for Tuberculosis)	❑	❑	_____
❑	❑	Ultrasound, abdominal	❑	❑	_____
❑	❑	Ultrasound, breast	❑	❑	_____
❑	❑	Ultrasound, pelvic	❑	❑	_____
❑	❑	Other_____	❑	❑	_____

Clinician Initials_____

Planned Parenthood of Delaware

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Family History

Yes No
❑ ❑ Are you adopted?

Has anyone in your family ever had the following?

Yes	No		Who?	Age when Diagnosed
❑	❑	Blood disease		
❑	❑	Coronary artery disease		
❑	❑	Heart attack		
❑	❑	Blood Clots		
❑	❑	CVA (Stroke)		
❑	❑	Diabetes		
❑	❑	High Cholesterol		
❑	❑	High blood pressure		
❑	❑	Osteoporosis		
❑	❑	Kidney failure		
❑	❑	Breast cancer		
❑	❑	Ovarian cancer		
❑	❑	Colon cancer		
❑	❑	Other_____		

Immunization History

Yes No
❑ ❑ Are your immunizations up to date?
❑ ❑ Have you received your MMR vaccination?
If yes, when? _____
❑ ❑ Have you received HPV?
If yes, how many doses? ❑ 1 ❑ 2 ❑ 3

REPRODUCTIVE HISTORY

Contraceptive History

Which birth control methods have you used in the past?

	Problems
❑ Pill / Patch / Ring	
❑ Depo	
❑ IUD (Type_____)	
❑ Implant device	
❑ Condoms	
❑ Tubal / Vasectomy	
❑ Other (Type_____)	

Menstrual History

❑ I have not had my period yet
❑ I am post-menopausal
Age at first period _____

How often do you get your period?
❑ More than once a month
❑ Monthly
❑ Less than once per month

Are your periods:
❑ Regular ❑Irregular

How many days do your periods last? _____

Is your flow: ❑ Light ❑ Moderate ❑ Heavy

Pregnancy History

_____ Number of pregnancies
_____ How many deliveries?
_____ How many miscarriages?
_____ How many abortions?

Pregnancy History (cont'd)

_____ How many ectopic (tubal) pregnancies?
_____ How many living children do you have?
_____ Age of first pregnancy
_____ Age of last pregnancy

Yes No
❑ ❑ Are you breast feeding?
❑ ❑ Any problems with pregnancy, birth, or abortion?
If yes, briefly explain_____

SOCIAL HISTORY

Sexual Practices / STI Risk

Yes No
❑ ❑ Have you had intercourse yet?
_____ If yes, how old were you the first time you had intercourse?
_____ How many sex partners have you had in the past year?

Check the types of sexual activity you have had?
❑ Anal ❑ Oral ❑ Vaginal ❑ None

Your partners are: ❑ Men ❑ Women ❑ Both

Your partner's partners:
❑ Men ❑ Women ❑ Both ❑ Unknown

Condom use: ❑ Always ❑Sometimes ❑Never

What method of birth control are you currently using?

Yes No Unknown
❑ ❑ ❑ Is your partner having sex only with you?
❑ ❑ Have you had a new partner since your last STI test?
❑ ❑ Have you had more than one partner in the last 12 months?
❑ ❑ ❑ Are you exposed to STI?
❑ ❑ ❑ Has a partner had STI symptoms in the past 60 days?
❑ ❑ Do you share needles?
❑ ❑ Have you ever accepted money/drugs for sex?
❑ ❑ ❑ Does your partner use IV drugs?
❑ ❑ ❑ Have you or a partner been incarcerated?
❑ ❑ Have you had anonymous partner(s)?
❑ ❑ ❑ Does your partner have other risk behaviors?
❑ ❑ Did you have a blood transfusion before 1985?

Substance Abuse

Yes No
❑ ❑ Have you used street drugs in the past?
Type_____
❑ ❑Are you currently using street drugs?
Type_____
❑ ❑Do you use alcohol?
Drinks_____per day/week/month
❑ ❑Do you have problems with drugs or alcohol?

Do you use tobacco?
❑Yes ❑No ❑Formerly Type_____
How much/often?_____

Lifestyle Challenges / Support

Yes No
❑ ❑ Have you/are you experiencing abuse?
❑ ❑ Have you been forced to have sex?

Patient Signature_____ Date_____

Clinician Initials_____