Planned Parenthood Southeast, Inc.
FEMALE HISTORY

PLEASE PRINT

NAME: _____ **DATE OF BIRTH:** ____/____/____ **AGE:** _____ **DATE:** _____

A. REVIEW OF SYSTEMS:		
YES	**NO**	**GENERAL**
		1. My health is generally good
		2. Smoke cigarettes. If yes how many per day? _____ How long? _____
		3. Alcohol use. If yes, how many drinks / week? _____
		4. Night sweats / hot flashes
		5. Cancer. If yes, where / when?
		6. Are you being treated for any illness / condition now? If yes, what?
		7. Do you currently take: medicine prescriptions, over the counter or herbal? If yes, name: _____
		8. Do you have other Health Care Providers? If yes, list:
		EYES
		9. Eye problems (except glasses or contacts)
		CARDIOVASCULAR
		10. Mitral Vale Prolapse
		11. Heart Murmur
		12. Varicose Veins
		13. Blood Clots (head / leg / lungs)
		14. Stroke or Stroke-like problems
		15. High Blood Pressure / Hypertension
		16. High Cholesterol (>200)
		RESPIRATORY
		17. Chronic Cough or other Breathing Problems / Asthma
		18. Tuberculosis (TB) or Exposure to Tuberculosis
		GASTROINTESTINAL
		19. Stomach or Bowel Problems: Ulcer / IBS / Constipation
		20. Liver Problems: Hepatitis / Tumor / Jaundice
		21. Gallbladder Problems
		GENITOURINARY
		22. Bladder or Kidney Problems
		23. Uterine Fibroids
		24. Ovarian Cysts
		25. Breast: Lump / Discharge / Surgery
		26. Vaginal Discharge that Itches / Burns or has Bad Odor
		27. Endometriosis
		28. Pain with Sex
		29. Previous Abnormal Pap. When?
		MUSCULOSKELETAL
		30. Arthritis
		31. Osteoporosis/Fragility Fractures
		SKIN
		32. Acne or Other Skin Problems. What?
		NEUROLOGICAL
		33. Migraine Headaches
		34. Seizures / Epilepsy
		35. Numbness in Arms / Legs (recurring)
		PSYCHOLOGICAL
		36. Depression/Eating Disorder, Requiring Treatment
		ENDOCRINE
		37. Thyroid Problems
		38. Diabetes / Gestational (during pregnancy)

YES	NO	HEMATOLOGICAL / LYMPHATIC
		39. Anemia
		40. Sickle Cell Disease / Trait
		41. Blood Clotting Disorder
		ALLERGY / IMMUNOLOGY
		42. Are you Allergic to any Drug, Medication, Latex or other Substance? If yes, what?
		43. Have you had? Vaccine for Rubella
		44. Have you had? Vaccine for HPV (human papilloma virus)
		45. Have you had? Vaccine for Hepatitis B
		BREAST
		46. Breast lump, pain or discharge?
		47. Skin changes in breast?
		48. History of abnormal mammogram?
		49. Breast biopsy? Right/Left/Both
		50. Breast Cancer?
		51. History of lobular carcinoma in situ (LCIS) and/or atypical hyperplasia of breast?
		52. Radiation treatments of the chest area (e.g. for treatment of Hodgkin's lymphoma)?
		53. Cancer of ovaries or intestines?
		OTHER
		54. Lupus (Systemic Lupus Erythematosus)
		55. Bariatric (weight loss) surgery

B. HOSPITALIZATION AND SURGERIES

Year	Reason

C. FAMILY HISTORY

56. Are you Adopted? ☐ Yes ☐ No

Have your **Biological Family** (parents, brothers, sisters) had any of the following?

YES	NO	CONDITION	RELATIVE
		57. Osteoporosis	
		58. Diabetes	
		59. Heart Attack/Stroke before age 55 Male / before age 65 Female	
		60. High Blood Pressure / Hypertension	
		61. High Cholesterol or fats	
		62. Genetic Problems	
		63. Did your Mother take DES when pregnant with you to prevent a miscarriage?	
		64. Cancer: Breast / Ovarian / Cervical (circle)	
		65. Cancer of Fallopian tube, intestinal	
		66. Anyone in your family ever tested for BRCA 1 or 2 gene mutation?	
		67. Family history of male breast cancer?	
		68. Of Jewish Ancestry? (Ashkenazi)	

D. BREAST CANCER RISK SCREENING (BRSQ)

YES	NO		
		69.1 Have you had breast or ovarian cancer?	
		69.2 Has a blood relative had breast or ovarian cancer?	

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E. PREGNANCY HISTORY ☐ NEVER BEEN PREGNANT

DELIVERED

Month	Year	Vaginal	C-Section	Age Now

MISCARRIAGE / ABORTION (AB)

Year	Weeks	Miscarriage	Medical AB	Surgical AB

F. CONTRACEPTIVE HISTORY

Current Birth Control Method:

How long used:

Any problems with this method? ☐ Yes ☐ No
If yes, what?

What method do you want to use now?

WHICH OF THE FOLLOWING METHODS HAVE YOU USED IN THE PAST:

YES	METHOD	COMMENTS / PROBLEMS
	Abstinence	
	☐ Tubal ☐ Vasectomy ☐ Hysterectomy	
	Oral Contraceptives (Pills)	
	Norplant / Implanon	
	Depo-Provera (shot)	
	IUD	
	Condoms	
	Sponge	
	Diaphragm	
	Rhythm/Natural Family Planning	
	Withdrawal	
	Patch	
	Ring	

G. SOCIAL HISTORY

YES	NO	HAVE YOU RECENTLY EXPERIENCED:
		70. Emotional Problems
		71. Relationship Problems
		72. Have You Experienced Domestic Violence?
		73. Are you Physically Abused?
		74. Are you Sexually Abused?
		75. Are you afraid of your ☐ Partner ☐ Family member?
		76. Do you feel alcohol or drugs are creating difficulties in your life?
		77. Do you have concerns about sexuality or sexual intercourse?
		78. Do you plan on having children?
		If yes, how many children would you like to have? _____
		When do you think you would like to start having children? ☐ 6 months ☐ 12 months ☐ 2-3 years ☐4-5 years

H. MENSTRUAL HISTORY

79. Age periods began:

80. Number of pads / tampons used on heaviest day:

81. Length of period (days):

82. Are your periods usually regular? ☐ Yes ☐ No

83. First Day of Last Period: _____
It seemed: ☐ Normal ☐ Abnormal

I. MENSTRUAL HISTORY CONTINUED

84. Do you experience, before or with periods: ☐ Cramps ☐ Bloating ☐ Bowel problems ☐ Emotional changes

85. Do you have vaginal bleeding after sex? ☐ Yes ☐ No

86. Do you have vaginal bleeding between menstrual periods: ☐ Yes ☐ No

J. SEXUAL HISTORY / STD RISK

87. Age you started having sex? _____

88. Sexual Partners? ☐ Male ☐ Female ☐ Both

89. Number of sexual partners during past year? _____

90. Are you currently having sex? ☐ Yes ☐ No If yes, which type(s): ☐ Vaginal ☐ Oral ☐ Anal ☐ Outercourse

91. Length of time with current partner? _____

92. Do you or your partner have other partners? ☐ Yes ☐ No ☐ N/A

93. Do you use Condoms: ☐ Always ☐ Sometimes ☐ Never

94. Have you ever had a Sexually Transmitted Infection? ☐ Yes ☐ No
Check type: ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ PID ☐ Trichamonas ☐ Herpes I (oral) ☐ Herpes II (genital) ☐ Syphilis

YES	NO	HIV RISKS:
		95. Are you HIV positive? If yes, when?
		96. Have you ever used street drugs? If yes, what drugs and when?
		97. Have you received blood or blood products since 1978?
		98. Was any partner: ☐ A street drug user ☐ A hemophiliac ☐ Infected with HIV / AIDS?
		99. Have you shared needles? Example: Injecting drugs, tattooing, or piercing

STAFF COMMENTS

To the best of my knowledge the information I have provided is correct and complete.

Client Signature **Date**

Staff Signature **Date**