Please use **BLUE** or **BLACK** ink *only*.

PLANNED PARENTHOOD OF INDIANA
MEDICAL HISTORY

Name____ Date of Birth______________ PPIN patient number__________

Reason for your visit today:____

CONTRACEPTIVE HISTORY

Check all birth control methods you have used: ___Pill ___Condom ___IUD ___ Diaphragm ___Sponge ___Cervical Cap ___foam/suppository ____DMPA (the shot) ____NuvaRing ___Natural Family Planning ___withdrawal ___sterilization ___Implanon ___Evra (patch) ___ Norplant ___other___________

YES NO Do you or your partner use any birth control or method to prevent pregnancy now?

YES NO If yes, what method(s) do you use?_______________________ How long have you used this method?________

YES NO Have you had problems with this or any birth control method? If yes, explain ____________________________

YES NO Do you plan to get pregnant in the next year?

YES NO Do you want a birth control method today? If yes, what method

MENSTRUAL HISTORY

Age periods started_________

How often do you get your period?

Number of days of flow?_____________

YES NO

- Was your last period normal?
- Have you had intercourse since your last period?
- Are you concerned that you could be pregnant now?
- Severe cramps?
- Missed periods?
- Bleeding between periods?

Please describe any problems you have with your periods NOW:

PREGNANCY HISTORY never pregnant (skip to next section)

Age at first pregnancy

Total pregnancies______

	Dates for each line
Elective abortions	__________
Miscarriages	__________
Still births	__________
Caesarean births	__________
Ectopic pregnancies (tubal)	__________
Live births	__________
Living children (add birthdates)	__________
Genetic abnormalities	__________
Gestational diabetes	__________

Are you breastfeeding now? yes no

SEXUAL HISTORY

Age at first intercourse_______________ How many lifetime partners have you had? _____

How frequently do you have intercourse?_______________Current partners? ____ Are your partners bi-sexual?_____

Are your partners at risk for STDs/HIV/hepatitis________? Does your partner use intravenous drugs? _______

YES NO

____ ____ Are you sexually active now? Check all that apply: ___ vaginal ___ anal ___ oral ___ other

____ _____Have you had more than one, or a new, sexual partner in the past year? Are your partners male female both?

____ _____Are you in a situation where you are being forced to have sex?

____ _____Do you feel that any of your partners have put you at risk for sexually transmitted infections, HIV, or hepatitis by being bi-sexual, recently in prison or jail or by using IV drugs? (please circle risk)

____ _____Do you have pain or bleeding with intercourse or other concerns about sex?

YES NO SOCIAL/ HEALTH RISK HISTORY

____ _____ Do you smoke? How many cigarettes a day?_________________

____ _____ Do you use alcohol? If yes, how often/how much?___________

____ _____ Do you use caffeine? Daily intake?_____________

____ _____ Do you or your partners use, or have you ever used, street or IV (injectable) drugs?

____ _____ Do you or your partners share needles of any kind?

____ _____ Have you ever had or would you like help now with an alcohol or drug abuse problem?

____ _____ Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?

____ _____ Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

____ _____ Do you feel unsafe at home?

____ _____ Is it hard to remember to use your seatbelt?

____ _____ Do you find it difficult to exercise? Activity________________________

____ _____ Do you have concerns about your weight? Diet? Eating disorder?

____ _____ Are you exposed to work hazards at your place of employment?

Please list any **ALLERGIES**, including drug, metal, latex, skin allergies, irritants, food or environmental. Also list the type of reaction____.

Please use **BLUE** or **BLACK** ink *only*.

BIOLOGICAL FAMILY HISTORY (If you are ADOPTED and DO NOT KNOW your biological family history, please skip this section.)

Has anyone in your immediate family ever had the following? If yes, indicate **father** (F), **mother** (M), **brother** (B), or **sister** (S).

_____ Death (age, cause of death)_____________ _______ Breast, ovarian, or uterine cancer (age at onset_____)

_____ Heart attack _____ stroke ________blood clot _______ Other cancer

_____ High blood cholesterol _____ high blood pressure _______ Diabetes (insulin dependent?__Yes __ No)

_____ Huntington's disease _____ Seizures _______ Thyroid problems _____ Osteoporosis ____renal disease

Clients born **in the U.S.** 1940-1970 **or born overseas:** Did your mother take DES (hormones) during her pregnancy with you?
__yes no

PAST MEDICAL HISTORY

Have you ever had surgery or been a patient in a hospital? yes no If yes, describe______________________________

Do you have a disability? yes no If yes, explain____

Are you now, or have you ever been, under a doctor's care for a serious illness or condition? yes no
If yes, describe____

List any and all medications or drugs you are now taking or take often, including over-the-counter medications, herbal medications, and vitamins______________________________. Do you take calcium? ☐ yes ☐ no Do you take folic acid? ☐ yes ☐ no

Do you have another source of health care? yes no Do you have a source of dental care? ☐ yes ☐ no

---

REVEW OF SYSTEMS Have you had or do you now have any of the following (please check each item)

1.General
YES NO
my health is generally good
recent weight gain or loss
frequent colds, flu, etc
chronic fatigue >6 months
cancer ______________
genetic condition
HIV/AIDS
blood or blood products transfusion

2.Immunizations
rubella (German Measles)
tetanus/diptheria (date of last)___
hepatitis A/B
☐ ☐ flu vaccine
☐ ☐ Gardasil (HPV) informed_____

3.Cardiovascular
varicose veins
high blood cholesterol
high blood pressure
heart disease/murmur
thrombophlebitis/blood clots in lungs or veins

4. Neurologic
seizures/ epilepsy
sensory difficulties (numbness, smell, taste, hearing)
migraine (diagnosed by MD)
stroke

5. Gastrointestinal
YES NO
stomach/ bowel problems
liver disease/jaundice/mono
hepatitis
gall bladder disease

6. Endocrine
diabetes/ diabetes of pregnancy
thyroid problems

7. Respiratory
asthma
chronic cough
TB

8. Genitourinary
frequent bladder infections (>3/yr)
bladder, urinary or kidney problems
recurrent vaginal infection
pelvic infection/pain/PID
breast problems: discharge, disease
Tumor, surgery
abnormal pap smear
sexually transmitted disease:
☐ ☐Chlamydia, Gonorrhea, Herpes
Syphilis, genital warts, other
Hepatitis A/B or C
abnormality of uterus/ovaries

9. Hematologic
YES NO
anemia
blood clotting disorder
blood transfusion
sickle cell/Thallesimia

10. Skin
acne
chronic rash/ itching
other skin problems

11. Musculoskeletal
broken bones/ fractures
arthritis
☐ ☐ osteoporosis

12. Eyes
☐ ☐ eye problems (not glasses/ contacts)

13. Psychology
under treatment
severe moodswings
anxiety
☐depression

14. Ears, nose , throat, mouth
frequent sore throat
teeth/gum problems
frequent nosebleeds
hearing problems

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.

Patient signature_______________________________________ **Date**_________________________

Clinician signature_________________________ Date__________ Staff signature_______________________ Date______

Anual review #1 ____age ____ LMP
no change change (see physical exam notes)

Clinician signature_________________________ Date __________ Staff signature_______________________ Date______

Annual review #2 ____ age ____LMP
no change change (see physical exam notes)

Clinician signature__________________________Date__________Staff signature ______________________ Date ________

PPIN #012-909