

**Central Montana Family Planning
Comprehensive Family Planning History**

Name: _____	
Today's date: _____	
Birth Date: _____	Age: _____
Primary Care Provider: _____	
List any prescriptions or over the counter medicines you are taking now _____	
List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: _____	

Your Medical History

Yes	No	Do you have now or have you had any of the following?	Staff Comments
<input type="checkbox"/>	<input type="checkbox"/>	Have you been to the ER or hospitalized in the last year?	
<input type="checkbox"/>	<input type="checkbox"/>	Surgery - List type and date: _____ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer: What type? _____ When? _____	
Ears/Nose/Mouth/Throat/Eyes			
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems (except glasses or contacts)	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	
Cardiovascular			
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease, murmur, high blood pressure	
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol/triglycerides	
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in arms/legs/chest	
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack or stroke	
Respiratory/Upper Body			
<input type="checkbox"/>	<input type="checkbox"/>	Breathing problems or Asthma	
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps or nipple discharge	
<input type="checkbox"/>	<input type="checkbox"/>	Mammogram and/or breast ultrasound Date: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or exposure to tuberculosis	
Gastrointestinal			
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or bowel problems	
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease (hepatitis, mono, jaundice, cirrhosis)	
Genitourinary			
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder problems	
<input type="checkbox"/>	<input type="checkbox"/>	Burning urination and/or blood in urine	
Musculoskeletal			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or osteoporosis	
<input type="checkbox"/>	<input type="checkbox"/>	Gout	
Skin			
<input type="checkbox"/>	<input type="checkbox"/>	Acne or other skin problems – Please specify: _____	
Endocrine			
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
Neurological			
<input type="checkbox"/>	<input type="checkbox"/>	Migraines or frequent headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or convulsions	
Hematological/Lymphatic			
<input type="checkbox"/>	<input type="checkbox"/>	Blood problems (Sickle cell anemia, hemophilia, low iron)	
<input type="checkbox"/>	<input type="checkbox"/>	Have you or your partner(s) ever had a blood transfusion, tissue/organ transplant or artificial insemination?	

Your Medical History (Continued)

Yes	No	Do you have now or have you had any of the following?	Staff Comments
Psychological			
<input type="checkbox"/>	<input type="checkbox"/>	Depression or emotional problems	

Your Family History

Please check here if you don't know your family history.

Yes	No	Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.	Staff Comments
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in arms/legs/chest _____	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems _____	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure _____	
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol/triglycerides _____	
<input type="checkbox"/>	<input type="checkbox"/>	Breast/ovarian/uterine/colon cancer _____	
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack _____	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	
<input type="checkbox"/>	<input type="checkbox"/>	Birth defects/genetic disorders _____	
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/drug abuse _____	
<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders _____	
<input type="checkbox"/>	<input type="checkbox"/>	Physical or sexual abuse _____	

Your Personal History

Yes	No	Do you have now or have you had any of the following?	Staff Comments
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or use any form of tobacco? How much per day? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? How many drinks a day? _____ Per week? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Do you ever feel you should cut down on your drinking?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you used marijuana in the past year?	
<input type="checkbox"/>	<input type="checkbox"/>	In the past year, have you used an illegal drug or a prescription drug for non-medical reasons?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been hit, slapped, kicked, shaken or hurt by anyone?	
<input type="checkbox"/>	<input type="checkbox"/>	Is there anyone who makes you feel unsafe now?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been forced to have sex?	

Immunizations – list date(s)

<input type="checkbox"/>	<input type="checkbox"/>	Measles, mumps, rubella (MMR) vaccine _____	
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus, diphtheria, pertussis (Td/Tdap) vaccine _____	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A vaccine _____	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B vaccine _____	
<input type="checkbox"/>	<input type="checkbox"/>	Varicella (chicken pox) vaccine _____	
<input type="checkbox"/>	<input type="checkbox"/>	HPV (human papilloma virus) vaccine _____	

Comprehensive Family Planning History

Your Sexual/Reproductive Health

Your Sexual History

Yes	No	Have you ever had any of the following sexually transmitted infections:	Staff Comments
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	
<input type="checkbox"/>	<input type="checkbox"/>	Genital warts/Human Papillomavirus (HPV)	
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	
<input type="checkbox"/>	<input type="checkbox"/>	Trichomoniasis	
<input type="checkbox"/>	<input type="checkbox"/>	Non-gonococcal urethritis (NGU)	
<input type="checkbox"/>	<input type="checkbox"/>	Have you or your sexual partner(s) ever used needles for drugs (to shoot drugs)?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you or your sexual partner(s) ever exchanged sex for drugs or money?	
<input type="checkbox"/>	<input type="checkbox"/>	Do you use condoms? <input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Always	
<input type="checkbox"/>	<input type="checkbox"/>	Have you had HIV testing? When? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Was the HIV test positive (HIV infection found)?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a new partner in the past 2 months?	
<input type="checkbox"/>	<input type="checkbox"/>	Does your sex partner have other partners?	

- How many sexual partners have you had in the past 2 months? _____
- How many sexual partners have you had in the past year? _____
- Are your sex partners: male female both
 transman transwoman intersex other
- Do you have: Vaginal sex Oral sex Anal sex
- When was the last time you had sex? _____
- Have any of your male partners had sex with other men?
 Yes No Not Sure N/A
- Are any of your sex partners living with HIV? Yes No

(Male/Assigned male at birth/MTF)		
Your Urological History		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have abnormal discharge from the penis now?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have now or in the past a lesion, sore, or lump on your penis? Describe: _____ When? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have now or had in the past a lesion, sore, or lump on your scrotum or testicles? Describe: _____ When? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had pain during sex? When? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had gender affirming surgery? If so, describe: _____

Your Reproductive History		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any children? How many? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you plan to have children? When? <input type="checkbox"/> Now <input type="checkbox"/> 1-2 Years <input type="checkbox"/> 3-5 Years <input type="checkbox"/> 5+ Years <input type="checkbox"/> Unsure
<input type="checkbox"/>	<input type="checkbox"/>	Are you using birth control? Please check the birth control method(s) you use: <input type="checkbox"/> Condoms <input type="checkbox"/> Vasectomy <input type="checkbox"/> Rely on partner's method. What method does your partner use? _____

(Female/Assigned female at birth/FTM)		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you plan to have children? When? <input type="checkbox"/> Now <input type="checkbox"/> 1-2 Years <input type="checkbox"/> 3-5 Years <input type="checkbox"/> 5+ Years <input type="checkbox"/> Unsure

Your Menstrual History

Date of the first day of your last menstrual period: _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Was your last menstrual period normal? If not, explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a period every month? Is the flow: <input type="checkbox"/> light <input type="checkbox"/> medium <input type="checkbox"/> heavy
<input type="checkbox"/>	<input type="checkbox"/>	Do you bleed between periods?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have cramps with your periods?
<input type="checkbox"/>	<input type="checkbox"/>	Do you take medication for cramps? <input type="checkbox"/> Over the counter <input type="checkbox"/> Prescription medication

How old were you when you had your first period? _____

Your Pregnancy History

How many times have you been pregnant? _____

List the dates that you gave birth: _____

How many living children do you have? _____

List the dates of any miscarriages or abortions: _____

List the dates of any tubal pregnancies: _____

Are you breast-feeding now? Yes No

Have you had a baby that weighed less than 5 1/2 pounds? _____

Have you had a baby that weighed more than 9 pounds? _____

During any pregnancy did you have high blood pressure, diabetes, or a baby with birth defects? _____

Your Gynecological History

When was your last Pap test done? Month _____ Year _____

Yes	No	Have you had any of the following?
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap test. If yes, when? _____
<input type="checkbox"/>	<input type="checkbox"/>	Was Colposcopy done? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Treatment for abnormal pap _____
<input type="checkbox"/>	<input type="checkbox"/>	Follow-up paps: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Did not follow up
<input type="checkbox"/>	<input type="checkbox"/>	Ovary problems
<input type="checkbox"/>	<input type="checkbox"/>	Uterus problems or uterine fibroids
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Inflammatory Disease (PID)
<input type="checkbox"/>	<input type="checkbox"/>	Pain or other problems with sex
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge that itches/burns or has a bad odor
<input type="checkbox"/>	<input type="checkbox"/>	Have you had gender affirming surgery? If so, describe: _____

Your Birth Control History

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you using a method of birth control now? If yes, what method? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you used any birth control methods that you have had a problem with? What method/s? _____
<input type="checkbox"/>	<input type="checkbox"/>	In the last 5 days or since your last period, have you had sex without birth control? (condoms are birth control)

Client Signature _____ Date _____

Staff Signature _____ Date _____

Client Signature: _____ Date Updated: _____

Staff Signature _____ Date _____