# Comprehensive Family Planning History

Fergus County Health Department — Central Montana Family Planning / Montana Cancer Screening Program
Promoting and improving the health of our communities.

Name: Date:

Date of Birth: Age:

Primary Care Provider:

List any prescriptions or over the counter medicines you are currently taking:

List any medicines / foods / latex / etc. that you are allergic to and the reaction you have from them:

## Your Medical History

| Do you currently have or have you previously had any of the following: | Yes: | No: | Staff Comments: |
|---|---|---|---|
| Have you been to the ER or hospitalized in the last year? | | | |
| Surgeries—type & date: | | | |
| Cancer—type & date: | | | |
| **Ears / Nose / Throat / Eyes** | | | |
| Eye problems (except glasses or contacts)? | | | |
| Hearing problems? | | | |
| **Cardiovascular** | | | |
| Heart disease, heart murmur &/or high blood pressure? | | | |
| High cholesterol &/or triglycerides? | | | |
| Blood clots in your arms, legs or chest? | | | |
| Heart attack or stroke? | | | |
| **Respiratory / Upper Body** | | | |
| Breathing problems &/or Asthma? | | | |
| Breast lumps &/or nipple discharge? | | | |
| Last mammogram &/or breast ultrasound: | | | |
| Tuberculosis &/or been exposed to tuberculosis? | | | |
| **Gastrointestinal** | | | |
| Stomach &/or bowel problems? | | | |
| Gall bladder disease? | | | |
| Liver disease (i.e. hepatitis, mono, jaundice, cirrhosis, etc.)? | | | |
| **Genitourinary** | | | |
| Kidney &/or bladder problems? | | | |
| Burning urination &/or blood in urine? | | | |
| **Musculoskeletal** | | | |
| Arthritis &/or osteoporosis? | | | |
| Gout? | | | |
| **Skin** | | | |
| Acne &/or other skin problems, please specify: | | | |
| **Endocrine** | | | |
| Thyroid problems? | | | |
| Diabetes? | | | |
| **Neurological** | | | |
| Migraines &/or frequent headaches? | | | |
| Epilepsy &/or convulsions? | | | |
| **Hematological / Lymphatic** | | | |
| Blood problems (i.e. sickle cell anemia, hemophilia, low iron, etc.)? | | | |
| Have you or your partner(s) ever had a blood transfusion, tissue / organ transplant or artificial insemination? | | | |
| **Psychological** | | | |
| Depression &/or emotional problems? | | | |

## Your Family History

| Have your grandparents, parents or siblings had any of the following: | Yes—who and age: | No: | Staff Comments: |
|---|---|---|---|
| Blood clots? | | | |
| Bleeding problems? | | | |
| High blood pressure? | | | |
| High cholesterol / triglycerides? | | | |
| Breast / ovarian / uterine / colon cancer? | | | |
| Heart attack? | | | |
| Stroke? | | | |
| Diabetes? | | | |
| Birth defects / genetic disorders? | | | |
| Alcohol / drug abuse? | | | |
| Mental health disorders? | | | |
| Physical or sexual abuse? | | | |

## Your Personal History

| | Yes: | No: | Staff Comments: |
|---|---|---|---|
| Do you smoke or use any form of tobacco? If so, how much per day: | | | |
| Do you drink alcohol? If so, how many drinks per day: Per week: | | | |
| Do you ever feel you should cut down on your drinking? | | | |
| Have you used marijuana in the past year? | | | |
| In the past year have you used an illegal drug or a prescription drug for non-medical reasons? | | | |
| Have you ever been hit, slapped, kicked, shaken or physically hurt by anyone? | | | |
| Is there anyone who makes you feel unsafe now? | | | |
| Have you ever been forced to have sex? | | | |

| Immunizations: | Yes: | No: | Date(s): |
|---|---|---|---|
| Measles, Mumps, Rubella (MMR) Vaccine | | | |
| Tetanus, Diphtheria, Pertussis (Td/Tdap) Vaccine | | | |
| Hepatitis A Vaccine | | | |
| Hepatitis B Vaccine | | | |
| Varicella (Chicken Pox) Vaccine | | | |
| HPV (Human Papilloma Virus) Vaccine | | | |

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## Your Sexual History

| Have you ever had any of the following sexually transmitted infections? | Yes: | No: | Staff Comments |
|---|---|---|---|
| Chlamydia | | | |
| Gonorrhea | | | |
| Genital warts / human papilloma virus (HPV) | | | |
| Syphilis | | | |
| Herpes | | | |
| Trichomoniasis | | | |
| Non-gonococcal urethritis (NGU) | | | |
| Have you or your sexual partner(s) ever used needles for drugs / to shoot drugs? | | | |
| Have you or your sexual partner(s) ever exchanged sex for drugs or money? | | | |
| Do you use condoms: Always ☐ Sometimes ☐ Never ☐ | | | |
| Have you had HIV testing? If so, when: | | | |
| Was the HIV test positive and /or HIV infection found? | | | |
| Have you had a new partner in the past 2 months? | | | |
| Does your sexual partner have other partners? | | | |

1. How many sexual partners have you had in the past 2 months?
2. How many sexual partners have you had in the past year?
3. Are your sex partners: Male ☐ Female ☐ Both ☐ Transman ☐ Transwoman ☐ Intersex ☐ Other ☐
4. Do you have: Vaginal sex ☐ Oral sex ☐ Anal sex ☐
5. When was the last time you had sex?
6. Have any of your male partners had sex with other men? Yes ☐ No ☐ Not sure ☐ N/A ☐
7. Are any of your sex partners living with HIV? Yes ☐ No ☐

## Male / Assigned at Birth Male / MTF

| Your Urological History | Yes: | No: |
|---|---|---|
| Do you have abnormal discharge from the penis now? | | |
| Do you have now or in the past a lesion, sore or lump on your scrotum or testicles? If so, when: Describe: | | |
| Have you ever had pain during sex? If so, when: | | |
| Have you had gender affirming surgery? If so, describe: | | |
| **Your Reproductive History** | | |
| Do you have children? If so, how many: | | |
| Do you plan to have children? If so, when: Now ☐ 1-2 Years ☐ 3-5 Years ☐ 5+ Years ☐ Unsure ☐ | | |
| Are you currently using birth control? If so, which method(s): Condoms ☐ Vasectomy ☐ Rely on partner's method ☐ Partner's birth control method: | | |

## Female / Assigned Female at Birth / FTM

| | Yes: | No: |
|---|---|---|
| Do you plan to have children? If so, when: Now ☐ 1-2 Years ☐ 3-5 Years ☐ 5+ Years ☐ Unsure ☐ | | |
| **Your Menstrual History** | | |
| Date of the first day of your last menstrual period: | | |
| Was your last menstrual period normal? If not, describe: | | |
| Do you have a period every month? | | |
| Is your flow typically: Light ☐ Medium ☐ Heavy ☐ | | |
| Do you bleed between periods? | | |
| Do you have cramps with your period? | | |
| Do you take medication for cramps? If so, is it: Over the counter ☐ Prescription medication ☐ | | |
| How old were you when you had your first period? | | |
| **Your Pregnancy History** | | |
| How many times have you been pregnant? | | |
| List dates you have given birth: | | |
| How many living children do you have? | | |
| List dates of any miscarriages / abortions: | | |
| List dates of any tubal pregnancies: | | |
| Are you currently breast feeding? | | |
| 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** | | |
| What is the date of your last Pap test? | | |
| Have you had an abnormal Pap test. If yes, when: | | |
| Was a colposcopy done? | | |
| Did you receive treatment for an abnormal Pap test? If so, what: | | |
| Were your follow-up Pap tests: Normal ☐ Abnormal ☐ No follow-up ☐ | | |
| Have you had ovarian problems? | | |
| Have you had uterine problems &/or uterine fibroids? | | |
| Have you had Pelvic Inflammatory Disease (PID)? | | |
| Have you had pain or other problems with sex? | | |
| Have you had vaginal discharge that itches, burns or has a bad odor? | | |
| Have you had gender affirming surgery? If so, describe: | | |
| **Your Birth Control History** | | |
| Are you currently using a method of birth control? If yes, which method(s): | | |
| Have you used any birth control methods that you have experienced problems with? If so, which method(s): | | |
| In the last 5 days or since your last period, have you had sex without birth control? (*Condoms are a form of birth control.) | | |

**Patient Signature:** _____ **Staff Signature:** _____

Date: _____ Date: _____

**Patient Signature:** _____ **Staff Signature:** _____

Date Updated: _____ Date: _____