Comprehensive Family Planning History

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			

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 coloscopy 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: ____________________

Date: ____________

Staff Signature: ____________________

Date: ____________

Patient Signature: ____________________

Date Updated: ____________

Staff Signature: ____________________

Date: ____________