Central Montana Family Planning
Comprehensive Health History

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Promoting and improving the health of our communities.

Patient Name: _____

Date of Birth: _____/_____/_____

Primary Care Provider: _____

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

_____

_____

Please list any medicines, foods, latex, etc. that you are allergic to and the reaction you have from them:

_____

_____

Medical History

Have you had any of the following?	Y	N	*Staff Notes*
ER or hospital visits in the last year?			
Surgeries? If *yes*, please list type(s) and date(s):			
Cancer? If *yes*, please list type(s) and date(s):			
Eye problems (excluding contacts or glasses)?			
Hearing problems?			
Heart disease, heart murmur and/or high blood pressure?			
High cholesterol and/or triglycerides?			
Blood clots in your arms, legs or chest?			
Heart attack or stroke?			
Breathing problems and/or Asthma?			
Breast lumps and/or nipple discharge?			
A mammogram and/or breast ultrasound before? If *yes*, please list most recent date:			
Tuberculosis and/or been exposed to it?			
Stomach and/or bowel problems?			
Gallbladder disease?			
Liver disease (i.e. hepatitis, mono, jaundice, cirrhosis, etc.)?			
Kidney and/or bladder problems?			
Burning urination and/or blood in urine?			
Arthritis and/or Osteoporosis?			
Gout?			
Acne and/or other skin problems? If *yes*, please list problems:			
Thyroid problems?			
Diabetes?			
Migraines and/or frequent headaches?			
Epilepsy and/or convulsions?			
Blood problems (i.e. sickle cell anemia, hemophilia, low iron, etc.)?			
You and/or your partner(s) had a blood transfusion, tissue or organ transplant or artificial insemination?			
Depression and/or other mental health problems?			

Family History

Have your grandparents, parents and/or siblings had any of the following? If "yes", please note who and age of occurrence.	Y	N	*Staff Notes*
Blood clots?			
Bleeding problems?			
High blood pressure?			
High cholesterol and/or triglycerides?			
Breast, ovarian, uterine, colon or other cancers?			

Have your grandparents, parents and/or siblings had any of the following? If "yes", please note who and age of occurrence.	Y	N	*Staff Notes*
Heart attack?			
Stroke?			
Diabetes?			
Birth defects and/or genetic disorders?			
Alcohol and/or drug abuse?			
Mental health disorders?			
Physical and/or sexual abuse?			

Personal

Please answer the following to the best of your ability.	Y	N	*Staff Notes*
Do you use any form of tobacco? If *yes*, how often and which form(s):			
Do you drink alcohol? If *yes*, how often and amount per time:			
Do you use marijuana? If *yes*, how often:			
Do you use an illegal drug or prescription drug for nonmedical reasons? If *yes*, how often:			
Have you been hit, slapped, kicked, shaken or physically hurt by anyone?			
Is there anyone who makes you feel unsafe now?			

Immunization History

Have you received the following vaccinations?	Y	N	*Staff Notes*
Measles, Mumps, Rubella (MMR)			
Tetanus, Diptheria, Pertussis (Tdap)			
Hepatitis A			
Hepatitis B			
Varicella (Chicken Pox)			
Human Papilloma Virus (HPV)			
Menigococcal B			

Sexual History

Have you ever tested positive for:	Y	N	*Staff Notes*
Chlamydia? Date(s):			
Gonorrhea? Date(s):			
Genital Warts or HPV? Date(s):			
Syphilis? Date(s):			
Herpes? Date(s):			
Trichomoniasis? Date(s):			
HIV? Date(s):			

Please answer the following to the best of your ability.	Y	N	NA	*Staff Notes*
Have you been tested for HIV? Most recent date:				
Are any of your sex partners living with HIV?				
Have you and/or your sex partner(s) used needles for drugs?				
Have you and/or your sex partner(s) exchanged sex for drugs or money?				
Last time you had sex?				
You and your partner(s) have: O vaginal sex O oral sex O anal sex				
You and your partner(s) have condomless sex?				
Have you had a new partner in the past 2 months?				
Does your sexual partner(s) have other partners?				
Number of sexual partners in the past 2 months?				
Number of sexual partners in the past 12 months?				
Gender(s) of sex partner(s): O male O female O both O transman O transwoman O intersex O other				
Have you been raped or forced to have sex without your consent? If yes, was it reported to authorities and when:				
Method of contraception used to avoid pregnancy?				
Have you experienced problems with a birth control method? Method(s):				
Have you had sex without a form of birth control (including condoms) since your last period?				
If yes, has this date been within the last 7-10 days?				
If yes, has this date been within the past 72-hours?				

Complete if you are male, assigned male at birth or are MTF

Please answer the following to the best of your ability.	Y	N	NA	*Staff Notes*
Do you have abnormal discharge from the penis?				
Do you have a lesion, sore and/or lump on scrotum or testicles? Date(s) and please describe:				
Do you have pain or other problems during sex? If *yes*, please describe:				
Have you had gender reaffirming surgery? If yes, please describe:				
Do you have children? If *yes*, how many:				
Do you plan to have children? If *yes*, when: O now O 1-2 years O 3-5 years O 5+ years O unsure				
Your current birth control method? O condoms O vasectomy O abstinence O rely on partner's method:				

Complete if you are female, assigned female at birth or are FTM

Please answer the following to the best of your ability.	Y	N	NA	*Staff Notes*
Your age of first period?				
First day of your last menstrual period date:				
Your most recent menstrual period was normal? If *no*, please describe:				
Do you have a period every month?				
Your typical flow is: O light O medium O heavy				
Do you bleed between periods?				
Do you have cramps with your period?				
Do you take medication for cramps? O prescription O over-the-counter				
Do you plan to have children? If *yes*, when: O now O 1-2 years O 3-5 years O 5+ years O unsure				
How many times have you been pregnant?				
What dates you have given birth:				
How many living children do you have?				
Miscarriage and/or abortion dates:				
Tubal pregnancy dates:				
Are you currently breastfeeding?				
Have you had a baby that weighed less than 5½ pounds?				
Have you had a baby that weighed more than 9 pounds?				
Have you had a pregnancy with high blood pressure, diabetes and/or a baby with birth defects?				
Your last Pap smear date:				
Have you had an abnormal Pap smear? If *yes*, please list results and date(s):				
Did you get treatment for an abnormal Pap smear? If *yes*, treatment type:				
Your follow-up Pap smears were: O normal O abnormal O no follow-up				
Do you have ovarian problems?				
Do you have uterine problems and/or uterine fibroids?				
Do you have Pelvic Inflammatory Disease (PID)?				
Do you have pain or other problems with sex? If *yes*, please describe:				
Do you have vaginal discharge that itches, burns or a bad odor?				
Have you had gender reaffirming surgery? If *yes*, please describe:				

Patient Signature: _____

Date: _____/_____/_____

Staff Signature: _____

Date: _____/_____/_____