MIDLAND COUNTY HEALTH DEPARTMENT
FAMILY PLANNING CLINIC

CONFIDENTIAL MEDICAL/SOCIAL HISTORY

DATE: ____________________

Name:____Birthdate:_______________Age:_____
(Last) (First) (Middle) (Birth Name)

Family History - Complete if you know any of your biological history
Are you adopted? (Y)___ (N)___

Check if any ***blood*** relative has had:	Cancer	Diabetes	Heart Disease Before age 50	High Blood Pressure	Blood Clots	Stroke
Grandparent/s						
Parent/s						
Sister/s						
Brother/s						

Personal History:

Do you have or have you had problems with:	**Yes**	**No**	**?**	**Staff Comments**
Cancer				
Diabetes, high blood sugar or sugar in urine				
Headaches – severe, frequent, migraine				
Eyes – blurred, double vision				
Dizzy spells, fainting				
Epilepsy, seizures, convulsions				
Heart – rheumatic fever, murmur, valve				
Stroke				
Blood clots in veins				
Varicose veins				
Bleeding disorder				
Anemia, Sickle Cell, or other blood disease				
Stomach – ulcer, indigestion				
Intestines – irritable bowel, rectal bleeding				
High cholesterol level				
Blood transfusion prior to 1984				
Lung Disease-Asthma, TB				
Kidney/bladder – infection				
Liver – hepatitis, jaundice, mono, tumor				
Gallbladder				
Thyroid				
High blood pressure				

Do you have or have you had problems with:	**Yes**	**No**	**?**	**Staff Comments**
Breasts – lump, cyst, nipple discharge				
Problems with ovaries or uterus				
Infection in uterus/tubes/ovaries				
Vaginal infection				
Genital warts				
Genital herpes				
Sexually transmitted disease				
Pain or bleeding during sex				
Depression - diagnosed or treated				
Allergies: Sulfa, Doxycycline, Copper, Penicillin, Cipro, Zithromax, Other				
Surgery				
Other hospitalization/s				
Eating disorder				
Type?				
Do you smoke? Number of cigarettes per day?				
Do you use drugs? What do you use?				
Do you use alcohol? Amount? Frequency?				
Have you been immunized for Hepatitis B?				
Rubella (German Measles)?				
Chickenpox (Varicella)?				
HepA				
HPV (Gardasil)				
Are you under a doctor's care now?				
What other health problems do you have?				
Medications you take routinely - list				

Menstrual/Gynecological History

First day of last menstrual period____________________

Number of days between the first day of one period and the start of the next period____________

Periods last how many days ________________________

Your age when regular period began ______________________

Your flow is light ________medium_________heavy_________

Are your periods regular? (Y)____(N)____ Are they normal? (Y)____ (N)____

Do you have: Premenstrual depression (Y)____(N)____

Cramps (Y)____(N)____

Water retention (Y)____(N)____

Bleeding between periods (Y)____(N)____

Missed periods (Y)____(N)____

If you were born before 1970 did your mother take DES? (Y)__(N)__

Is this your first pelvic exam? (Y)____ (N)____

Last physical ___________ Last Pap smear ____________

History of abnormal Pap smear? (Y)__(N)__

How old were you when you first had vaginal intercourse? ______________________________

Are you in a sexual relationship now? (Y)_____ (N)_____

When was the last time you had sex?________________________________

Do you have sex with men? _________Women? ________Both men and women?____________

Have you had a new partner in the past 12 months? (Y)_____(N)_____

How many lifetime partners? _________

How many partners have you had in the past 12 months? __________________

Have any of your partners had a history of: bisexuality_______ injectable drug use _____
multiple partners_______ or ever been at risk for STIs or HIV?_________?

Have you possibly been exposed to a sexually transmitted disease? (Y____ (N)____ (?)____

Do you have pain, burning or other problem when you urinate? (Y)____ (N)____

How do you protect yourself from HIV/AIDS? ____

Do you do self-breast exams? (Y)____(N)____

Contraception History

Have you had vaginal sex **without** using a condom or other birth control method since your last menstrual period? (Y)___ (N)___

Have you had a method failure since your last menstrual period? (Y)___(N)___

Have you had unprotected vaginal sex in the past 72 hours? (Y)___ (N)___

Are you regularly using a birth control method? (Y)____ (N)____

What method/s do you use? Abstinence___ Condoms____ Pill____ IUD____ Sponge___ Diaphragm___
Foam/jelly/cream/inserts ____ Depo Provera Injection ___ Implanon ____
Natural ___Withdrawal____ Contraceptive Ring___ Contraceptive Patch ___ Sterilization____

Where was the method obtained? Midland Health Dept ___ Other Clinic___ Drug store___
Private physician___ Hospital___ Other_____________________

How long have you used this method? _______________________

Do you want to continue your current method of birth control? (Y)___ (N)___

If not, what method do you want to use instead? ____

What other method/s have you used? ____

What caused you to stop using that method? ____

What method/s would you prefer now? ____

Why? ____

Pregnancy History

Have you ever been pregnant? (Y)___ (N)___

If *YES*, fill in the following:

Date of delivery or end of pregnancy	Complications	Live Birth	Still Birth	Miscarriage	Abortion	Number of Months	Birth Weight

Number of living children ______________________

Are you currently breast-feeding? (Y)___ (N)____

Do you think you may be pregnant now? (Y)___ (N)____

Do you want any (more) children? (Y)____(N)____

Have you been trying to get pregnant?________How long have you been trying?________

How often do you and your partner have sex?___________

Do you know what time of the month you can get pregnant?________

Social History

With whom do you live? ____

Have you ever been physically or emotionally abused by your partner or someone else who is important to you? (Y)___ (N)___

Have you been hit, slapped, shoved, punched, kicked or in any way physically hurt? (Y)___(N)___

Has anyone forced you to have sex? (Y)___(N)___

Was this reported to the authorities? (Y)___(N)___

Have you had counseling? (Y)____(N)____

Have you been forced to have sex by your current partner? (Y)___(N)___

Are you afraid of your partner? (Y)___(N)___

Are you afraid of anyone in your life? (Y)___(N)___

Were you forced to come here for birth control today? (Y)__________(N)_____________

Do you feel threatened or unsafe right now? (Y)___ (N)____

Have you or your partner traveled anywhere in the last 8 months? If so, when and where?___________________________________

Do you or your partner plan to travel in the near future?_________________________

To the best of my knowledge, the above information is complete and accurate.

Client Signature____Date________________

Reviewed by: ____ Date________________