Semcac Family Planning Clinic

[Patient Label]

Medical History

All Information is strictly confidential.

Have you had any of the following? Answer only questions applicable to you:	Yes	No		Yes	No		Yes	No
Abnormal Pap Smear			Eating Disorder: Anorexia / Bulimia			Problems with Uterus / Ovaries / PCOS		
Colposcopy and/or Treatment			Gall Bladder Disease					
Anemia/Polycythemia			Genetic Disorder			Seizures / Epilepsy		
Bariatric Surgery			Heart Murmur / Disease / Stroke			Solid Organ transplant		
Bleeding or Bruising Disorder			Hepatitis/Liver Disease / Jaundice			System Lupus Erythematosus		
Blood Clots in vein / leg / lung			High Blood Pressure					
Blood Transfusion			High Cholesterol			Thyroid condition		
Exposure to Blood Products			Kidney/ Urinary tract (Bladder) Infection			**Immunization for:**		
Breast Disease / Breast Surgery			Kidney/Adrenal insufficiency			Tetanus		
Cancer			Mental Disorder			Hepatitis B		
Chemical Dependency			Depression / Diagnosed Anxiety			Rubella/MMR		
Diabetes / Gestational Diabetes			Migraines / Frequent Headaches			HPV (Gardasil)		

Allergies (medications, latex, iodine, metal, skin allergens etc.): _____

Medications (including over the counter), vitamins, herbs or supplements you are taking: _____

_____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No Explain_____

_____

Are you being treated for any illness or condition now?_____

Are you now or have you in the past 3 months experienced? Please only answer questions applicable to you:

	Yes	No		Yes	No
Fever/Night Sweats			Swollen lymph nodes		
Pain with ejaculation			Unexplained fatigue		
Scrotal/Testicle pain or swelling			Unexplained weight loss		
Skin rashes/sores/bumps			Urethral discharge		
Sore throat			Urinary difficulty/pain/blood		

History of cervical cancer screening: ☐ N/A

When was your last pap smear? _____

Was it normal? ☐ Yes ☐ No _____

Menstrual History: ☐ N/A

1st day of your last menstrual period _____

Was your last period normal and on time?

☐ Yes ☐ No

Age at first menses (period): _____

How often do your periods come (from the first day of one period to the first day of the next)? _____(Ex: 28 days)

How many days do you bleed? _____

Are your periods: ☐ light ☐ moderate ☐ heavy

Obstetrical History: ☐ N/A

☐ Never been pregnant (skip Obstetrical History)

List number of:	Dates
Births/Deliveries: _____	_____
Abortions: _____	_____
Miscarriages: _____	_____
Living Children: _____	_____

Circle any of the complications you experienced:

Cesarean, Premature Birth, Twins/Multiples, Still Birth, Gestational Diabetes, Ectopic, Genetic Abnormality

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Semcac Family Planning Clinic

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Family Medical History:

Were you adopted? ☐Yes ☐No

**Please mark if your biological Father (F), Mother (M), Brother (B), or Sister (S) have had the following:

____ Cancer of ovary, breast, colon or uterus
____ Heart Attack/ Stroke before age 65
____ High Blood Pressure/ High Cholesterol
____ Diabetes
____ Depression/ Mental Disorder
____ Chemical Dependency
____ Mother took DES during pregnancy
____ Other:_____

Health Risk History:

Do you smoke or use tobacco?
☐ Yes, socially
☐ Yes, every day
How many per day?_____
Do you want to quit?_____
☐ No, former smoker. How long?_____
☐ No, never

Do you use alcohol? ☐ Yes ☐ No
How many times per week? _____
How many drinks per occasion? _____

Do you use street drugs? ☐ Yes ☐ No
Explain: _____

Do you do any form of regular exercise? ☐ Yes ☐ No
What? _____
How often? _____

Do you wear a seatbelt?
☐Never ☐ Sometimes ☐ Always

Do you perform self-breast exams? ☐Yes ☐ No
How often?: _____

Do you perform self-testicular exams? ☐Yes ☐ No
How often?: _____

Sexual History:

Are you currently sexually active? ☐Yes ☐ No ☐Never
☐Vaginal ☐Oral ☐ Anal

Are you partners: ☐ Male ☐Female ☐ Both

Do you practice safe sex to protect against sexually transmitted infections (ex: condoms, dental dams)?
☐ Never ☐ Occasionally ☐ Always

Do you want to be tested for sexually transmitted infections?
☐Yes ☐ No

Have you been exposed to any infectious disease?
☐Yes ☐ No

Do you have a history of any sexually transmitted infections?
☐Chlamydia ☐ PID ☐Trichomonas
☐Gonorrhea ☐ HIV ☐Genital Herpes
☐Syphilis ☐ Hep B ☐HPV/Genital Warts
Other: _____

Number of sexual partners within the past 12 months? _____
Number of NEW sexual partners within past 3 months? _____

Safety:

Have you or any sexual partner ever used IV drugs or shared needles (including drug needles, piercing or tattoos)?
☐Yes ☐ No

Has your partner or a family member ever hit, punched, kicked, or physically hurt you or threatened to hurt you?
☐Yes ☐ No

Do you feel safe in your relationship and in your home?
☐Yes ☐ No

Have you ever been forced to have sex/do something sexual, or been touched against your will? ☐ Yes ☐ No

If yes, have you had counseling? ☐ Yes ☐ No

Contraceptive History: ☐ N/A

Are you currently using any method of birth control, including condoms? ☐ Yes ☐ No
If no, check: ☐ Abstinent
☐ Female partner
☐ Trying to get pregnant

What method are you using? _____
How long have you used this method? _____
Are you having any problems with this method? ☐Yes ☐ No
Explain: _____
_____

Do you want to continue your current method? ☐Yes ☐ No
If no, what do you want to switch to? _____

Have you used any other methods in the past? ☐ Yes ☐No
If yes, what?_____
Explain any problems: _____
_____

Are you planning a pregnancy in the next year?
☐ Yes
☐ No

Are you concerned you could be pregnant now?
☐ Yes
☐ No

Do you have any questions or concerns about sex that you would like to discuss? ☐ Yes ☐No
Explain: _____
_____
_____

*****To the best of my knowledge this information is complete and correct*****