Comprehensive Family Planning History

Name: _____

Today's date: _____

Birth Date: _____ Age: _____

Primary Care Provider: _____

List any prescriptions or over the counter medicines you are taking now

_____

List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: _____

Your Medical History

Yes	No	Do you have now or have you had any of the following?	Staff Comments
☐	☐	Have you been to the ER or hospitalized in the last year?	
☐	☐	Surgery - List type and date: _____ _____ _____	
☐	☐	Cancer: What type? _____ When? _____	
		Ears/Nose/Mouth/Throat/Eyes	
☐	☐	Eye problems (except glasses or contacts)	
☐	☐	Hearing problems	
		Cardiovascular	
☐	☐	Heart disease, murmur, high blood pressure	
☐	☐	High cholesterol/triglycerides	
☐	☐	Blood clots in arms/legs/chest	
☐	☐	Heart attack or stroke	
		Respiratory/Upper Body	
☐	☐	Breathing problems or Asthma	
☐	☐	Breast lumps or nipple discharge	
☐	☐	Mammogram and/or breast ultrasound Date: _____	
☐	☐	Tuberculosis or exposure to tuberculosis	
		Gastrointestinal	
☐	☐	Stomach or bowel problems	
☐	☐	Gall bladder disease	
☐	☐	Liver disease (hepatitis, mono, jaundice, cirrhosis)	
		Genitourinary	
☐	☐	Kidney or bladder problems	
☐	☐	Burning urination and/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 (Sickle cell anemia, hemophilia, low iron)	
☐	☐	Have you <u>or your partner(s)</u> ever had a blood transfusion, tissue/organ transplant or artificial insemination?	

Your Medical History (Continued)

Yes	No	Do you have now or have you had any of the following?	Staff Comments
		Psychological	
☐	☐	Depression or emotional problems	

Your Family History

☐ Please check here if you don't know your family history.

Yes	No	Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.	Staff Comments
☐	☐	Blood clots in arms/legs/chest_____	
☐	☐	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? How much per day? _____	
☐	☐	Do you drink alcohol? How many drinks a 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 hurt by anyone?	
☐	☐	Is there anyone who makes you feel unsafe now?	
☐	☐	Have you ever been forced to have sex?	

<u>Immunizations</u> – list 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 _____

Comprehensive Family Planning History
Your Sexual/Reproductive Health

Your Sexual History

Yes	No	Have you ever had any of the following sexually transmitted infections:	Staff Comments
☐	☐	Chlamydia	
☐	☐	Gonorrhea	
☐	☐	Genital warts/Human Papillomavirus (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? ☐ Never ☐ Sometimes ☐ Always	
☐	☐	Have you had HIV testing? When? _____	
☐	☐	Was the HIV test positive (HIV infection found)?	
☐	☐	Have you had a new partner in the past 2 months?	
☐	☐	Does your sex 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 male at birth/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 penis? Describe: _____ When? _____
☐	☐	Do you have now or had in the past a lesion, sore, or lump on your scrotum or testicles? Describe: _____ When? _____
☐	☐	Have you ever had pain during sex? When? _____
☐	☐	Have you had gender affirming surgery? If so, describe: _____

Your Reproductive History

☐	☐	Do you have any children? How many? _____
☐	☐	Do you plan to have children? When? ☐ Now ☐ 1-2 Years ☐ 3-5 Years ☐ 5+ Years ☐ Unsure
☐	☐	Are you using birth control? Please check the birth control method(s) you use: ☐ Condoms ☐ Vasectomy ☐ Rely on partner's method. What method does your partner use? _____

(Female/Assigned female at birth/FTM)

Yes	No	
☐	☐	Do you plan to have children? When? ☐ Now ☐ 1-2 Years ☐ 3-5 Years ☐ 5+ Years ☐ Unsure

Your Menstrual History

Date of the first day of your last menstrual period: _____

Yes	No	
☐	☐	Was your last menstrual period normal? If not, explain: _____
☐	☐	Do you have a period every month? Is the flow: ☐ light ☐ medium ☐ heavy
☐	☐	Do you bleed between periods?
☐	☐	Do you have cramps with your periods?
☐	☐	Do you take medication for cramps? ☐ 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 the dates that you gave birth: _____
_____
How many living children do you have? _____
List the dates of any miscarriages or abortions: _____
List the dates of any tubal pregnancies: _____
Are you breast-feeding now? ☐ Yes ☐ No

☐	☐	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

When was your last Pap test done? Month_____ Year _____

Yes	No	Have you had any of the following?
☐	☐	Abnormal Pap test. If yes, when? _____ Was Colposcopy done? ☐ Yes ☐ No
☐	☐	Treatment for abnormal pap _____
☐	☐	Follow-up paps: ☐ Normal ☐ Abnormal ☐ Did not follow up
☐	☐	Ovary problems
☐	☐	Uterus problems or uterine fibroids
☐	☐	Pelvic Inflammatory Disease (PID)
☐	☐	Pain or other problems with sex
☐	☐	Vaginal discharge that itches/burns or has a bad odor
☐	☐	Have you had gender affirming surgery? If so, describe: _____

Your Birth Control History

Yes	No	
☐	☐	Are you using a method of birth control now? If yes, what method? _____
☐	☐	Have you used any birth control methods that you have had a problem with? What method/s? _____
☐	☐	In the last 5 days or since your last period, have you had sex without birth control? (condoms are birth control)

Client Signature _____ Date _____ Staff Signature _____ Date _____

Client Signature: _____ Date Updated: _____ Staff Signature _____ Date _____