

Patient History Form

PLACE PATIENT LABEL HERE

NAME _____ Date ____/____/____

E. PREGNANCY HISTORY <input type="checkbox"/> never pregnant								
DELIVERED					ABORTION / MISCARRIAGE			
Mo.	Yr.	Vag.	C-Sec.	Birth Weight	Year	Weeks	Spont.	Induced

F. CONTRACEPTIVE HISTORY

Current birth control method? _____ How long used? _____

Any problems with this method? Yes No

If yes, what? _____

What method do you want to use now? _____

Total number of children desired? _____

Are you planning a pregnancy in the NEXT year? Yes No

If not, what would you do if you become pregnant within the NEXT year? _____

Which of the following methods have you used in the past?

METHOD	COMMENT/PROBLEM
<input type="checkbox"/> Abstinence?	
<input type="checkbox"/> Tubal? <input type="checkbox"/> Vasectomy? <input type="checkbox"/> Hysterectomy?	
<input type="checkbox"/> Birth Control Pill?	
<input type="checkbox"/> The Patch?	
<input type="checkbox"/> The Ring?	
Implant: <input type="checkbox"/> Norplant? <input type="checkbox"/> Implanon?	
<input type="checkbox"/> Depo-Provera (The Shot)?	
<input type="checkbox"/> IUD?	
<input type="checkbox"/> Condoms?	
<input type="checkbox"/> Diaphragm? <input type="checkbox"/> FemCap? <input type="checkbox"/> Lea's Shield?	
<input type="checkbox"/> Sponge? <input type="checkbox"/> Spermicide?	
<input type="checkbox"/> Rhythm?	
<input type="checkbox"/> NFP (Natural Family Planning)?	
<input type="checkbox"/> Withdrawal?	

G. SOCIAL HISTORY

Emotional? Relationship problems?

Death of Family member? Friend?

Job loss? Financial problems?

Problems in Living arrangements? School?

Legal problems? Arrests? Divorce?

Do you have any parental problems? _____

Are you physically abused? _____

Has anyone forced you to have sex? _____

Are you sexually abused? _____

Are you afraid of your Partner? Family member?

Who helps and supports you with your problems? _____

H. MENSTRUAL HISTORY

1. Age periods began? _____

2. Number of pads / tampons used on heaviest day? _____

3. Length of period? _____ (days) # of days between periods?

4. Are your periods usually regular? Yes No

5. Last period started on _____
It seemed Normal Not normal

6. Do you experience, before or with periods, Cramps? Bloating?
 Bowel problems? Emotional changes?

7. Do you have vaginal bleeding after sex? Yes No

8. Do you have vaginal bleeding between menstrual periods? Yes No

I. STI / HIV RISKS

Number of sex partners in your life? _____ MEN _____ WOMEN _____

How many sex partners have you had during the past year? _____

Does your partner have sex with men women both?

Do you have (check all that apply) vaginal oral anal sex?

COMMENTS

Have you ever used street drugs?
If yes, when? _____

Have you received blood or blood products prior to 1978? _____

Were any of your partners:
 a street drug user? a hemophiliac?
 infected with HIV / AIDS?
 MSM (men having sex with men)?

Have you ever shared needles? Examples:
Injecting drugs, tattooing, piercing? _____

STAFF COMMENTS (do not write anything in this space)

To the best of my knowledge the information I have provided is correct and complete.

Patient Signature _____ Date _____

Staff Signature _____ Date _____

History reviewed:

Staff Signature _____ Date _____

Staff Signature _____ Date _____