INITIAL PATIENT HISTORY FORM (Females Only)

Patient Name | Birthdate | Age | Clinic | Patient Number

CURRENT MEDICAL STATUS (PLEASE CIRCLE)

DO YOU NOW HAVE OR HAVE YOU EVER HAD (circle type)?	Yes	No
a. Dizziness/Blurred Vision/Severe Headaches		
b. Epilepsy/Seizures		
c. Serious or Prolonged Depression/Anxiety		
d. Eating Disorder		
e. Asthma/Lung Problems		
f. Thyroid Problems		
g. Heart Problems/High Blood Pressure/Stroke		
h. Liver Problems/Jaundice/Hepatitis/Immunization		
i. Kidney/Bladder Problems or Infections		
j. Diabetes/Hypoglycemia/Gestational Diabetes		
k. Rubella (German measles)/Immunization		
l. Blood clots-legs or elsewhere:		
m. Do you have any concerns about physical abuse?		
n. Do you have other medical problems or chronic diseases?		

o. Cancer: ☐ Yes ☐ No Type: _____ When: _____

p. Do you smoke cigarettes or cigars? ☐ Yes ☐ No

Pks. per day? _____ Duration: _____

q. Take or use any alcohol or any street drugs? What? _____

How often? _____

r. Hospitalization/Surgery:

When? _____

Why? _____

FAMILY HISTORY/GENETIC SCREENING

DOES YOUR NATURAL MOTHER, FATHER, SISTER, BROTHER OR GRANDPARENTS HAVE OR HAVE THEY EVER HAD ANY OF THE FOLLOWING:

	Who	Age of Onset
a. Diabetes		
b. Heart disease/high blood pressure		
c. Cystic Fibrosis		
d. Neural tube defect		

e. Cancer? ☐ Yes ☐ No Who: Type:

f. Are you and your partner considering pregnancy in the next 2 years? ☐ Yes ☐ No

g. Did your mother take DES while pregnant? ☐ Yes ☐ No

h. Do you or your partner come from one of the following ethnic backgrounds?
☐ Black ☐ Mediterranean ☐ Jewish ☐ Hispanic

i. Are you or your partner blood relatives? ☐ Yes ☐ No

j. Are you 34 years or older and considering pregnancy? ☐ Yes ☐ No

k. DO (DID) ANY OF THE FOLLOWING RELATE TO YOUR FAMILY, YOUR PARTNER, OR YOUR PARTNER'S FAMILY?

	Yes	Who
Birth defects, specify problem:		
Mental Retardation		
Inherited blood disorders		
Two or more miscarriages		
Lost a child after 5th month of pregnancy or shortly after birth		
Other Genetic Disorders:		

l. Is there anything that runs in your family that concerns you about having a child? ☐ Yes ☐ No

m. Would you like genetic information? ☐ Yes ☐ No ☐ Refused

Referred to _____

MEDICATION HISTORY

List all medications you are taking now (include birth control pills, prescription drugs, and vitamins):

List medication and/or latex allergies: None known: ☐

GYNECOLOGICAL/PREGNANCY HISTORY

a. First day of last period? _____

b. Age period began? _____ Age period ended? _____

c. Date and result of last mammogram: _____

d. Have you ever had an abnormal Pap exam? ☐ Yes ☐ No When: _____

e. Are you sexually active? ☐ Yes ☐ No

Have you ever been sexually active? ☐ Yes ☐ No Age Began: _____

f. Are your periods regular? ☐ Yes ☐ No

g. Do you have pain or bleeding during intercourse? ☐ Yes ☐ No

h. Do you have breast problems? ☐ Yes ☐ No

i. Do you examine your own breasts? ☐ Yes ☐ No

How Often? _____

j. Do you or have you had ovary/uterus problems? ☐ Yes ☐ No

k. Do you or have you had any unusual vaginal bleeding or discharge? ☐ Yes ☐ No

l. Have you had a STD (syphilis, gonorrhea, chlamydia, herpes) HIV/AIDS? ☐ Yes ☐ No

Do you have concerns about them? ☐ Yes ☐ No

m. Have you had vaginal infections/pelvic infections/genital sores? ☐ Yes ☐ No

n. Number of times pregnant? _____ Age at first pregnancy? _____

o. Could you be pregnant now? ☐ Yes ☐ No

p. Have you ever tried to get pregnant and couldn't? ☐ Yes ☐ No

COMPLETE THE FOLLOWING FOR EACH PREGNANCY

Date Pregnancy Ended	Problems with Pregnancy or Delivery	Mis-carriage (✓)	Abortion	C-Section (✓)	Weight of Baby	No. Months Pregnant

CONTRACEPTIVE HISTORY

a. Your current method of birth control? _____ For how long? _____

b. List any methods ever used and any problems you had with them: _____

I UNDERSTAND THAT ALL INFORMATION DISCUSSED WILL REMAIN CONFIDENTIAL.

Patient Signature Date

STAFF NOTES:

Staff Signature Date

INITIAL MEDICAL EXAM RECORD

Date of Visit | Patient Number | Age

COUNSELING/EDUCATION

	Discussed	Materials Given
Reproductive Anatomy/Physiology:	☐	☐
Methods of Contraception:	☐	☐
Emergency Contraception:	☐	☐
Spec. Ed. on Adolescent Sexuality:	☐	☐
Abstinence as an Option	☐	☐
Parental Involvement	☐	☐
Coercive sexual activities	☐	☐
Breast Self-Exam:	☐	☐
STD/HIV Prevention/Risk Assessment:	☐	☐
Problem Conceiving a Child:	☐	☐
Partner History:	☐	☐
Emergency Contact of Clinic Staff:	☐	☐
Other: (specify): _____	☐	☐

Patient's choice of method after counseling: _____

NOTES:

BMI _____

Immunizations Yes No

Has patient demonstrated understanding of C/E? ☐ Yes ☐ No

Follow-up counseling/education necessary? ☐ Yes ☐ No *STAFF SIGNATURE/TITLE/DATE:* _____

LABORATORY

Vital Signs: | Weight: | Height: | Blood Pressure:

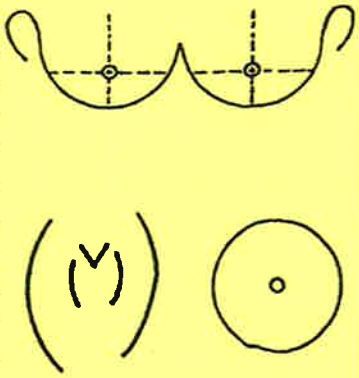
	Done	Refused	NA	WNL	Results
Hct or Hgb					
Pap Test					
GC Test					
Chlamydia Test					
Vaginal Smear					
Pregnancy Test					

Other (specify; e.g. Urine Chemistry):

PHYSICAL EXAMINATION

	WNL	ABN	COMMENTS AND ADDITIONAL DATA
Skin			
Breasts			
Cardiorespiratory			
Thyroid			
Abdomen			
Extremities			
External Genitalia			
Vagina (discharge)			
Cervix			
Uterus: Size/Shape/Position			
Adnexum			
Rectal:			

NOTES



Other physical findings (specify):

ASSESSMENT SUMMARY/MEDICAL PLAN/TREATMENT:

(Summarize condition/referral/follow-up/contraceptives [brand, dosage, size, instructions])

CLINICIAN SIGNATURE/TITLE/DATE: _____ *NEXT APPT.* _____