Comprehensive Family Planning History

Patient Identification:

Today's date: _____
Birth date: _____ Age: _____
List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: _____

Your Family History

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

Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age.

Yes	No	
☐	☐	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_____
☐	☐	Alcohol/drug abuse_____

Your Medical History

Do you have now or have you had any of the following?

Yes	No	
☐	☐	Are you taking any prescription or over the counter medicines now? Please list: _____
☐	☐	Have you been to the ER or hospitalized in the last year?
☐	☐	Asthma
☐	☐	Heart disease, high blood pressure
☐	☐	Blood clots in arms/legs/chest
☐	☐	Heart attack or stroke
☐	☐	High cholesterol/triglycerides
☐	☐	Migraines or frequent headaches
☐	☐	Visual changes or numbness
☐	☐	Lupus (SLE)
☐	☐	Cancer: What type? _____ When? _____
☐	☐	Blood problems (Sickle cell anemia, hemophilia, low iron)
☐	☐	Have you or your partner(s) ever had a blood transfusion, tissue/organ transplant or artificial insemination?
☐	☐	Inflammatory bowel disease (IBD)
☐	☐	Gall bladder disease
☐	☐	Surgery - List type and date:_____
☐	☐	Thyroid problems
☐	☐	Breast disease
☐	☐	Mammogram - date _____
☐	☐	Kidney or bladder problems
☐	☐	Liver disease (hepatitis, mono, jaundice, cirrhosis)
☐	☐	Diabetes
☐	☐	Epilepsy or convulsions
☐	☐	Depression or emotional problems

Your Personal History

Yes	No	
☐	☐	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?

Your Nutritional History

Yes	No	
☐	☐	Are there changes you would like to make to your diet? If yes, describe:_____
☐	☐	Do you exercise regularly? Describe: _____

List any supplements, herbs or weight loss preparations you use:
_____

Immunizations (list date(s))

Yes	No	
☐	☐	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_____
☐	☐	Flu vaccine_____

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Your Sexual/ Reproductive Health

Have you ever had any of the following sexually transmitted infections:

Yes	No	
☐	☐	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 ____Top ___Bottom ____Both ____? Ana l sex____ Top ___Bottom ____Both_____?
5. When was the last time you had sex? _____
6. Have any of your male partners had sex with other men? Yes ____ No ____ 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? Describe: _____
☐	☐	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

Yes	No	
☐	☐	How many children do you have? _____
☐	☐	Do you want children in the future?
☐	☐	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)

Do you want to become pregnant in the next year? Yes __ No __

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 __

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? _____

Yes	No	**Have you had any of the following?**
☐	☐	Abnormal Pap test If yes, when? _____
☐	☐	Colposcopy or treatment of your cervix (When?)_____
☐	☐	Ovary problems
☐	☐	Uterus problems or uterine fibroids
☐	☐	Pelvic Inflammatory Disease (PID)
☐	☐	Pain or other problems with sex
☐	☐	Vaginal infections (yeast or bacterial vaginosis)
☐	☐	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_____ Provider signature _____Date_____

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Client signature _____Date_____ Provider signature _____Date_____