PORTSMOUTH CITY HEALTH DEPARTMENT

FAMILY PLANNING HISTORY

PATIENT NAME _______________ **PHARMACY** _______________ **DOB** __________ **AGE:** ____

PAST OR PRESENT ILLNESS (circle all that apply):
☐NONE

Diabetes   Asthma   Hepatitis   Cancer

Heart Disease   Thyroid Disorder   Anemia

Liver Disease   Kidney Disease   Blood Clotting Disorder

Depression/Anxiety   High Blood Pressure

High Cholesterol   Seizure Disorder

FAMILY HISTORY:

Relative (Mother, Father, etc)	Diagnosis	Age

MEDICATION(S):

Medication Allergies: ☐NONE ☐SEE LIST

____

Current Medications & Prescribing Doctor: ☐NONE

____

____

MAJOR OPERATIONS (SURGERY & YEAR): ☐NONE

____

LIFESTYLE/RISK FACTORS:

Alcohol?
☐ Less than 2 beers per day
☐ More than 2 beers per day ☐ None

Condom Use? ☐ No ☐ Occasionally ☐ Yes

Diet? ☐Balanced ☐ Overeating ☐ Undereating

Drug Use? ☐Heroin ☐Inhaled ☐Marijuana
☐Other(s) ☐Downers ☐Uppers ☐ None

Physical Activity/Exercise?
☐Mild Exercise ☐Occasional Vigorous Exercise
☐Regular Vigorous Exercise ☐Sedentary (no exercise)

Are you currently sexually active? ☐ Yes ☐ No
Number of Partners in the last year? __________

Have you ever had a Sexually Transmitted infection?
☐ Yes ☐ No
If so, what? ☐ Chlamydia ☐ Trichomonas
☐Herpes ☐ Gonorrhea ☐ Syphilis ☐ HIV

Tobacco Use?
☐ Current User: Packs per day ________
☐ Decreasing Tobacco ☐ Never ☐ Recently Quit

Immunizations

Rubella Vaccine	☐Yes	☐No	☐Not Sure
Hepatitis B Vaccine Series	☐Yes	☐No	☐Not Sure
Gardasil (HPV) Series	☐Yes	☐No	☐Not Sure
Flu Shot (this year)	☐Yes	☐No	☐Not Sure

Emotional History

☐Yes ☐No When you feel sad, do you bounce back quickly or feel sad for 2 weeks or more?

How often do you feel nervous, anxious or worried?
☐Daily ☐Weekly ☐Monthly ☐Seasonal

Social History

☐Yes ☐No	Are you adopted?
☐Yes ☐No	Someone hits, slaps, kicks, or hurts you?
☐Yes ☐No	Someone who often says hurtful or mean things?
☐Yes ☐No	Afraid of your partner(s)/other
☐Yes ☐No	Alcohol and/or drug problems in your life?
☐Yes ☐No	Are others concerned about your alcohol/drug habits?
☐Yes ☐No	Parents aware of your visit today?

PLEASE CONTINUE ON REVERSE SIDE→

Reproductive Life Plan

IN YOUR IMMEDIATE FAMILY, PLEASE LIST THE # OF:

Live Births _____**Date(s)** ____________________
Premature Births _____**Date(s)** ____________________
Tubal Pregnancies Births _____**Date(s)** ____________________
Abortions _____**Date(s)** ____________________
Living Children _____**Date(s)** ____________________
C-Sections _____**Date(s)** ____________________
Miscarriage(s) _____**Date(s)** ____________________

Please mark if you have had any of the following problems with any pregnancy with you or in your immediate family:

☐Gestational Diabetes ☐Genetic Abnormalities
☐High Blood Pressure ☐Preterm Labor
☐Two or more miscarriages ☐Stillborn
☐Baby with heart defect
☐Baby born too soon or weighing less than 5 ½ pounds

Sexual History

Age when you first had sex? __________

How many times ________month/year are you having sex?

Have you ever been sexually abused/raped?
☐Yes ☐No

Does your partner have sex with females?
☐Yes ☐No

Does your partner have sex with males? ☐Yes ☐No

Does your partner have sex with both male and female? ☐Yes ☐No

Are you and your partner only with each other?
☐Yes ☐No

Type of sex practiced:
With a male? ☐Oral ☐Anal
With a female? ☐Oral ☐Vaginal ☐Anal

Do you think of yourself as:
☐Lesbian, gay or homosexual
☐Straight or heterosexual
☐Bisexual
☐Something else
☐Don't know

Males Only

Do you perform self testicular exams?
☐Yes ☐No

Females Only

Menstrual Cycle

First day of your last period: _________
Was your last period normal? _______________
Age when period started: __________________
Periods come every________________days
Bleeding lasts____________________days
Periods are: ☐Regular ☐Irregular ☐Painful
Flow is: ☐Light ☐Normal ☐Heavy

Pap History

Last Pap smear: ____________
Was it normal? ___________
Have you ever had an abnormal pap smear? _______
If so, when? _________________________________
Did you receive any treatment? ___________________

Breast Exam

Do you do Self Breast Exam? ☐Yes ☐No

Birth Control

Current form of birth control:_________________________
Any side effects?_______________________________________
Other forms of birth control used in the past:
____

Any side effects? ______________________________________

Pregnancy

Have you ever been pregnant? ☐Yes ☐No
Do you have plans for future pregnancy? ☐Yes ☐No
If yes, how many? ______________________________________
At what age would you like to have children? _________
How far apart would you like your children to be? ____
If you where pregnant would you be happy
☐Yes ☐No
Would it be difficult for you to support a child currently?
☐Yes ☐No
What will you do if you become pregnant?
____

PATIENT SIGNATURE ____**DATE:**______________________

PATIENT NAME (PLEASE PRINT) ____