FEMALE FAMILY PLANNING HEALTH HISTORY FORM

Last Name	First	Date of birth	Age	Date today
Home phone ( ) O.K. to contact? YES ☐ NO ☐	Other contact name		Other contact phone ( )	

What is your household size? ______

What is your household income? ______

What is the main reason for your visit today? ______

Are you allergic to any medicines, shellfish, or copper?
NO ☐ YES ☐ Which ones, what happened? ______

Do you take (or are you supposed to take) medicines, natural remedies, aspirin, or other drugs every day?
NO ☐ YES ☐ List them: ______

Have you ever had or do you have:

NO	YES		NO	YES	
☐	☐	Diabetes	☐	☐	Problems with your kidneys or bladder
☐	☐	Seizures	☐	☐	Bone disease or weak bones
☐	☐	Heart attacks or strokes	☐	☐	Cancer
☐	☐	High blood pressure	☐	☐	Breast surgery or problems
☐	☐	Depression	☐	☐	Pelvic infection treated in the hospital
☐	☐	Migraines or bad headaches	☐	☐	Uterine fibroids or Ovarian cysts
☐	☐	Blood clot in your blood vessels like the leg or lung	☐	☐	Eczema or bad skin rashes
☐	☐	Hepatitis (turned yellow) or gallbladder problem	☐	☐	Ectopic or tubal pregnancy
☐	☐	Any other serious medical condition, surgery, or hospitalization	☐	☐	Blood transfusions or IV Drug use
			☐	☐	Exposure to DES inutero (if born between 1940 and 1970)

Has anyone in your IMMEDIATE family (mother, father, sister, brother, daughter, son, or if your parents are less than 50 give information about other relatives) had any of the following:

		NO	YES	
Cancer:	Who, what type and at what age found?	☐	☐	______
Diabetes:	Who, and at what age?	☐	☐	______
Heart Attack:	Who, and at what age?	☐	☐	______
Stroke:	Who, and at what age?	☐	☐	______
Blood clots in blood vessels like the leg or lung:	Who, and at what age?	☐	☐	______

Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape, we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.

Do you use tobacco? NO ☐ YES ☐ How much do you use? ______ How many years? ______

Do you drink alcohol? NO ☐ YES ☐ How often? ☐ daily ☐ weekly ☐ monthly
How many alcoholic drinks do you have at a time? ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5+ drinks

Do you use other drugs (examples: marijuana, cocaine or IV drugs? NO ☐ YES ☐
What do you use? ______ How often? ☐ daily ☐ weekly ☐ monthly

Pacific County is an Equal Opportunity Employer

Do you feel safe from violence in your personal relationships? NO ☐ YES ☐

____

Have you ever had a sexually transmitted disease or genital infection? NO ☐ YES ☐
Circle the ones you might have had:

Chlamydia	Gonorrhea	Herpes	Genital Warts	PID	Syphillis
HIV	Bacterial Vaginosis	Trichomonas	Hepatitis B or C	Yeast	

How many different sex partners have you had in the last 12 months? ____________

Were your partners *(circle correct answers)*: men women both IV drug users Bisexual
a partner with multiple sex partners or at risk for HIV or STD infection

How long have you been with your current sex partner? ____________ Age you first had sex. ____________

What type of sex have you had in the past 2 months? *(circle the types)*

Vaginal Oral Anal Other No Sex

Do you have symptoms of a genital infection? NO ☐ YES ☐ *(circle the ones you have)*

Discharge	Odor	Itch	Rash
Bumps	Sores	Pain with sex	Bleeding after sex
Burning	Stool or anal problems	Pain with urination	Urgent or frequent urination

---

Have you used a birth control method before? NO ☐ YES ☐ *(circle the types you have used and write in years of use)*

Pills	Condoms	Diaphragm/Cervical Cap	Implant
IUD	Shot/Depo	Vasectomy/Tubal	Abstinence
Withdrawal	Suppository/Film/Foam	Natural Family Planning/Rhythm	Other
Patch/Ring	Emergency Contraceptive Pills		

What do you use now? ____

List any problems with your current methods: ____

Have you used birth control pills or injections for more than 5 years? NO ☐ YES ☐
(this can prevent cancer of the ovaries and uterus)

Are you up to date with your immunizations like Rubella or Hepatitis? NO ☐ YES ☐ UNKNOWN ☐

How old were you when you had your first period? Age: ______ Are your periods painful? NO ☐ YES ☐

For your most recent period, what was the first day bleeding started? Date ______________________

How many days do your periods last? # of days: ______ Do you bleed between periods? NO ☐ YES ☐

How many days from the start of one period until the start of the next period? # of days: ______________

Have you had unprotected sex within the past 72 hours? NO ☐ YES ☐

Do you think you could be pregnant today? NO ☐ YES ☐

Do you ever douche or use genital deodorant sprays, powders or wipes? NO ☐ YES ☐

Pacific County is an Equal Opportunity Employer

Will this be your first pelvic exam today? NO ☐ YES ☐ Date of your last Pap test? ____________

Have your Pap tests been normal? NO ☐ YES ☐

If you have had an abnormal Pap test, when, where, and what was done? ____________

Have you ever been pregnant? NO ☐ YES ☐ *(If no, you are done)* Are you breastfeeding? NO ☐ YES ☐

# of pregnancies	________	# of deliveries	________	# of ectopics	________
# of living children	________	# of abortions	________	# of miscarriages	________

If you have been pregnant before, when did your last pregnancy end? ____________

When you were pregnant, did you get diabetes? NO ☐ YES ☐

Have any of your babies been 10 pounds or more? NO ☐ YES ☐ No babies ☐

History reviewed by: ____________

Date Reviewed: ____________

Pacific County Public Health and Human Services Department

1216 W. Robert Bush Dr., South Bend, WA
360-875-9343
605 S. Oregon, Long Beach, WA
360-642-9349

Revised 4/26/10

Pacific County is an Equal Opportunity Employer