# Medical History

**Reason for today’s visit:**

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The following information will help us provide you with the highest quality care. Please fill out this health history as completely as possible. Thank you.

### Medical History

**Do you now have or have you had any of the following? Check all that apply.**

- [ ] Anemia/blood disorder
- [ ] Anesthesia Complications
- [ ] Blood transfusion
- [ ] Bleeding problems/blood disease
- [ ] Blood clots in veins
- [ ] Heart problems/surgery
- [ ] High blood pressure
- [ ] Stroke
- [ ] Severe varicose veins
- [ ] Rhogam injection/Rh negative
- [ ] Heart murmur
- [ ] Chest pain
- [ ] High cholesterol
- [ ] Nasal polyps
- [ ] Asthma/shortness of breath
- [ ] Bronchitis
- [ ] Sinusitis/allergies
- [ ] Frequent headaches
- [ ] Migraine headaches
- [ ] Muscle or nerve disease
- [ ] Blurred vision/blackouts
- [ ] Epilepsy/seizures
- [ ] Fainting
- [ ] Hepatitis/seizures
- [ ] Gall bladder problems
- [ ] Kidney/bladder problems
- [ ] Thyroid disorder
- [ ] Hiatal hernia
- [ ] Ulcer
- [ ] Gastric Bypass surgery
- [ ] Bowel problems
- [ ] Breast problems
- [ ] Surgery on reproductive organs
- [ ] Sickle cell trait
- [ ] Cancer
- [ ] Diabetes
- [ ] Glaucoma/eye problems
- [ ] Rheumatism
- [ ] Tuberculosis
- [ ] Alcoholism
- [ ] Drug addiction
- [ ] Depression
- [ ] Suicidal thoughts/attempt
- [ ] Eating disorder
- [ ] Panic/anxiety disorder
- [ ] Have you ever been physically assaulted?
- [ ] Loose, false or chipped teeth
- [ ] Obstructive sleep apnea

Please list any allergies you have, and their reactions:

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**Are you currently taking any medications? Please list any prescriptions, supplements, vitamins or over-the-counter medications:**

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Do you have or have you had any medical problems? What are they?

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Are you currently breastfeeding? [ ] yes  [ ] no

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### Social History

**Would you like referrals or additional information for any of the following?**

- [ ] Domestic violence
- [ ] Rape/Sexual assault
- [ ] Physical abuse
- [ ] Alcohol or drug dependency
- [ ] Domestic violence
- [ ] Emergency contraception
- [ ] Quitting smoking
- [ ] Emotional problems

**If you are here for a termination...**

Do you feel that you have emotional support? [ ] yes  [ ] no

How are you feeling about your decision to have an abortion?

- [ ] Very sure
- [ ] Sure
- [ ] Unsure
**Current Symptoms**

Are you currently experiencing any of the following? How long? Check all that apply.

- Abdominal pain
- Lower backache
- Genital burning
- Genital itching
- Unusual discharge
- Has your sexual partner had any of the symptoms listed above? Which ones?
- How long?

- Irregular bleeding
- Pain during or after intercourse
- Bleeding after intercourse
- Pain during or after orgasm
- Rash/bumps/sores in genital area
- Bloody urine

- Fever
- Pain/burning with urination
- Frequent urination
- Small amounts of urine

**Reproductive Health History**

Do you have or have you had any of the following? Check all that apply.

- Abnormal Pap smear result
- Biopsy/colposcopy
- Laparoscopy/laparotomy
- Cervical/uterine cancer
- Cancer: __________
- Endometriosis
- Endometritis (infection of the uterus)
- Vaginal infection
- Unusual discharge
- Vaginal infection
- Genital itching
- Genital sore
- Abnormal uterus shape/position
- Fibroids
- Pelvic Inflammatory Disease (PID)
- Chlamydia
- Gonorrhea
- HPV/genital warts
- Herpes
- Syphilis
- Bacterial vaginosis (BV)
- Breast lump/cancer
- Infertility problems
- Urinary tract infection (UTI)
- Pre-eclampsia/toxemia
- Excessive bleeding
- Date of last Pap smear: __________
- Have you had the HPV vaccine? How many doses? _____
- Other

Please list the total number of:

**Pregnancy History**

<table>
<thead>
<tr>
<th>If pregnant, is this your first pregnancy?</th>
<th>Preganancies</th>
<th>Births</th>
<th>Premature Deliveries</th>
<th>Abortions</th>
<th>Miscarriages</th>
<th>Living Children</th>
<th>Cesarean sections</th>
<th>Ectopic</th>
<th>Genetic Defects</th>
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</tbody>
</table>

Please explain any pregnancy complication:

**Menstrual History**

- Age at first period: __________
- Date last period began: __________
- Was it a normal period? yes no
- If not, please explain:

- Your periods are: regular irregular absent painful
- Your periods come about every _____ weeks for _____ days.
- On heavy days, number of pads/tampons used daily: _____
- Any recent changes in your menstrual pattern? yes no
- If so, what changes? __________________________

**Sexual History / Orientation**

- At what age did you first have sexual intercourse? __________
- Are you currently having sex? yes no
- Check all that apply: vaginal oral anal
- Do any of your sexual partners have a (check all that apply):
  - uterus
  - penis
- How many partners have you had in the past 60 days? _____
- Has your partner been sexual with anyone else in the last 12 months?
  - Yes
  - Not Sure
  - No
- Yes No Have you...
- Used a condom the last time you had intercourse?

**Contraceptive History**

What, if any, form of birth control are you currently using?

Any problems with it?

Do you want to change your method of birth control? If so, which method(s) are you interested in?

Have you used any of these contraceptives in the past?

- The Pill
- Depo Provera
- IUD
- Male Condom
- Female Condom
- Foam/Jelly
- Sponge
- Cervical cap
- Diaphragm
- Rhythm/Fertility Awareness Method
- ECT/Emergency Contraceptive
- The Patch
- Vaginal Ring
- Withdrawal
- Implant

Any problems with them?

Do you want children in the future? yes no unsure

**Additional Information**

Emergency Contact:

- Please provide the name, relationship to you (i.e. friend, significant other, etc.), and number of your emergency contact:
- Name:
- Relationship to you:
- Phone number:

Can we leave a voicemail at this number if we cannot reach you first?

- Yes
- No

Preferred Pharmacy:

- Name:
- Address:

Address: __________________________________________

Name:    __________________________________________

Relationship to you:___________________________

Other, etc.), and number of your emergency contact: