



**FAMILY PLANNING ASSOCIATES MEDICAL GROUP
PATIENT HISTORY**

Name _____ Date _____

Birth Date _____ Age _____ Message Phone () _____

In the event of an emergency or abnormal lab results, we will make every reasonable effort to contact you.

YOUR Medical History (NOT YOUR FAMILY'S HISTORY)

Check "YES" OR "NO" (please do not leave this section blank):

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	PID (Pelvic Inflammatory Disease)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Infections
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Have You Had A Pap Smear?
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots in Veins	<input type="checkbox"/>	<input type="checkbox"/>	Headaches			_____ (Year)
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Body/Facial Piercing(s)	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease:
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Severe Depression			_____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anesthesia Problems (List below)	<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Problems:
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia (List below)			_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	C-Sections (List Years and Reasons):			_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems			_____			_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (List all Foods, Meds, Latex):			_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders			_____			_____

Pregnancy History

Number of Live Births: ____ Abortions: ____ Miscarriages: ____ Stillbirths: ____ Ectopic or Molar: ____ **Total:** ____
 Problems with pregnancies: _____

Surgeries: _____

Are you receiving medical care for any type of medical problem? _____

If other medical conditions explain: _____

Previous anesthesia or medication problems: _____

Have you ever used recreational drugs? _____ What Drugs _____ Last Time _____

Are you currently taking any medications, herbs, diet pills, or vitamins? _____

If yes, specify dosage and frequency, or write "unknown": _____

Serious injuries: _____

Do you smoke cigarettes? _____ If yes, how many cigarettes per day? _____

Have you ever smoked? _____ If you quit, when? _____ How many cigarettes per day did you smoke? _____

Have you consumed alcohol in the past 24 hours? _____ What type and quantity? _____

Could you, or someone close to you, benefit from a referral for counseling or other help for any form of sexual or physical violence or verbal/emotional abuse? YES NO

Family Medical History

Has anyone in your immediate family ever had:

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stroke		High Blood Pressure
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Problems with Anesthesia

Menstrual History

How old were you when you started your period? _____

Do you have your period every month? _____

How many days do you flow? _____

Is it? Heavy Moderate Light **(Circle one)**

PATIENT TO COMPLETE: What method(s) of birth control have you used (please circle all that apply): pills, condoms, IUD, withdraw, shots, the nuva ring, foam/film, implant, fertility awareness, diaphragm, other. What method are you using now? _____

What problems did you have with these methods? _____

What method would you like to use now? _____

FPA STAFF TO COMPLETE:

CHC OK Yes No
 Needs 35 and Older Form

FPA: NP PA CNM MD

MD/NP/PA/CNM Signature: _____

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