

Please list any **ALLERGIES**, including drug, metal, skin allergies or irritants, or rubber/latex sensitivity_____

FAMILY HISTORY

If you are adopted, check and skip to the next section.

Has anyone in your immediate family ever had the following? If yes, indicate father (F), mother (M), brother (B), or sister (S).

_____ No longer living (Age/Cause of death: _____) _____ Breast, Ovarian or Uterine Cancer (age at onset: _____)
_____ Heart Attack/Heart Disease/Surgery (Age at onset: _____) _____ Other Cancer
_____ High Blood Cholesterol/High Blood Pressure _____ Diabetes Yes No

Women born 1940-1970: Did your mother take DES (hormones) during her pregnancy with you? Yes No

MEDICAL HISTORY

List current medications including herbs and over the counter meds: _____

YES NO

- Have you ever had surgery or been a patient in a hospital?
If yes, describe: _____
- Are you now, or have you been, under a doctor's care for a serious illness or condition?
If yes, describe: _____
- Do you have another source of health care? Where? _____

REVIEW OF SYSTEMS

Have you had or do you now have any of the following (please check each item):

YES	NO	1. <u>General</u>	YES	NO	5. <u>Gastrointestinal</u>	YES	N O	9. <u>Hematologic</u>
<input type="checkbox"/>	<input type="checkbox"/>	My health is generally good	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain or loss (> 25 lbs)	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease/jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting disorder
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds, flu, ext.	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue (> 6 months)	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia/Trait/Thalassemia/PKU
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	6. <u>Endocrine</u>		<input type="checkbox"/>	10. <u>Skin</u>
<input type="checkbox"/>	<input type="checkbox"/>	Genetic Condition	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Diabetes of pregnancy		<input type="checkbox"/>	Acne
<input type="checkbox"/>	<input type="checkbox"/>	2. <u>Immunizations</u>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic rash/itching
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	7. <u>Respiratory</u>	<input type="checkbox"/>	<input type="checkbox"/>	Other skin problems
<input type="checkbox"/>	<input type="checkbox"/>	Vaccine/shot for Rubella/MM	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	11. <u>Musculoskeletal</u>
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus Vaccine shot	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	3. <u>Cardiovascular</u>	<input type="checkbox"/>	<input type="checkbox"/>	Other breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones/fractures
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Murmur	<input type="checkbox"/>	<input type="checkbox"/>	8. <u>Genitourinary</u>	<input type="checkbox"/>	<input type="checkbox"/>	12. <u>Eyes</u>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Cholesterol/Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	Frequent bladder infections (> 3 per year)	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems (other than glasses)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bladder, urinary or Kidney problems		<input type="checkbox"/>	13. <u>Ears, Nose, Throat, Mouth</u>
<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis/Blood Clots In veins or lungs	<input type="checkbox"/>	<input type="checkbox"/>	Abnormality of uterus	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems
<input type="checkbox"/>	<input type="checkbox"/>	4. <u>Neurologic</u>	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic infection/Pain/PID	<input type="checkbox"/>	<input type="checkbox"/>	Teeth/Gum problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent vaginal infections	<input type="checkbox"/>	<input type="checkbox"/>	14. <u>Psychology</u>
<input type="checkbox"/>	<input type="checkbox"/>	Migraine (Diagnosis by MD)	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease: Chlamydia/Gonorrhea/Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Sensory difficulties (numbness, hearing, taste, smell)	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis/Genital Warts/Other	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Visual changes (blurring, spots, lines in front of eyes)	<input type="checkbox"/>	<input type="checkbox"/>	Breast problems: Discharge/	<input type="checkbox"/>	<input type="checkbox"/>	Severe mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Disease/Tumor/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Under care of Psychiatrist/Psychologist
			<input type="checkbox"/>	<input type="checkbox"/>	Do you check your breasts?	Results		Treatment
			<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smear Dates			

FILL THIS OUT IF YOU ARE UNDER 18 YEARS OLD

YES NO

- Are your parents aware of your visit to Family Planning?
 If not, did you discuss your plans to come to the clinic with another adult? Who? _____
 Would you like information on talking to your parents about sexuality?
 Are you in a relationship where you are being forced to have sexual relations?

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.

Patient Signature _____ Date of Birth _____ Date _____

Comments:

Staff Signature _____ 10/2004