Panhandle Health District

Name _____ **FAMILY PLANNING HISTORY**

A. REVIEW OF SYSTEMS		
YES	NO	GENERAL
		1. My health is generally good
		2. Night sweats/hot flashes
		3. Cancer. If yes, where/when?
		4. Smoke cigarettes. If yes, how many per day?
		5. Alcohol use. If yes, how many drinks/week?
		6. Birth defects or genetic problems
		7. Are you being treated for any illness/condition now? If yes, what?
		8. Do you currently take medicine: ☐ prescription ☐ over the counter ☐ herbal? If yes, name:
		EYES
		10. Eye problems (except glasses or contacts)
		EAR/NOSE/MOUTH/THROAT
		11. Hearing problems
		12. Frequent nosebleeds
		CARDIOVASCULAR
		13. Mitral Valve Prolapse
		14. Heart murmur
		15. Varicose veins
		16. Blood clots (head/leg/lungs)
		17. Stroke or stroke-like problems
		18. High blood pressure
		19. High Blood Pressure requiring treatment
		20. High Cholesterol
		RESPIRATORY
		21. Chronic cough or other breathing problems/asthma
		22. Tuberculosis or exposure to tuberculosis
		GASTROINTESTINAL
		23. Stomach or bowel problems
		24. Liver problems (hepatitis or tumor, etc.)
		25. Gallbladder problems
		GENITOURINARY
		26. Bladder or kidney problems
		27. Uterine fibroids
		28 Ovarian cysts
		29. Breast lump or discharge
		30. Last Mammogram (breast X-Ray) Date: _____
		31. Vaginal discharge that itches/burns or has a bad odor
		32. Endometriosis
		33. Pain with sex
		34. Previous abnormal pap
		35. Last PAP Date: _____
		36. Did your mother take DES when she was pregnant with you? (If born before 1975)
		37. History of sexually transmitted infection. Check type: ☐ chlamydia ☐ gonorrhea ☐ genital warts ☐ herpes ☐ syphilis ☐ PID ☐ Hepatitis B ☐ HIV ☐ Other
		38. Your age at first vaginal intercourse. AGE: _____
		MUSCULOSKELETAL
		39. Arthritis or osteoporosis
		SKIN
		40. Acne or other skin problems. What?
		NEUROLOGICAL
		41. History of Migraine headaches **with vision changes**?
		42. Seizures/epilepsy
		43. Numbness in arms/legs (recurring)
		PSYCHOLOGICAL
		44. Depression - requiring treatment
		45. Suicide thoughts and/or plans?

A. REVIEW OF SYSTEMS (cont.)		
YES	NO	ENDOCRINE
		46. Thyroid problems
		47. Diabetes
		HEMATOLOGICAL/LYMPHATIC
		48. Anemia
		49. Sickle cell disease/trait
		50. Blood clotting disorder
		ALLERGY/IMMUNOLOGY
		51. Lupus
		52. Ever had Rubella? (German measles)
		53. Have you had all your childhood Immunizations
		54. Tetanus shot in last 10 years? Date:
		55. Have you completed Hep B Series Yes No
		56. Have you had the HPV vaccine for cervical cancer?
		57. Are you **allergic** to any drug, medication, **latex** or other substance, including local anesthesia? **If yes, what?**

B. HOSPITALIZATION AND SURGERIES

Year		Reason		

C. FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

Have your **parents, brothers, or sisters** had any of the following?

YES	NO	Diagnosis	Relative	
		Osteoporosis		
		Diabetes		
		Heart attack/stroke before age 50		
		High blood cholesterol or fats		
		High blood pressure		
		Genetic problems		
		Blood clots/clotting disorder		
		Cancer: If yes, type:		

STAFF COMMENTS / EXPLANATIONS (by number)

Label # 5

Please complete reverse side