

SOCIAL AND LIFESTYLE HISTORY		Y	N	FAMILY MEDICAL HISTORY			
Do you experience feelings of depression that prevent you from carrying out your usual activities & responsibilities?				Have any of your <i>immediate</i> family members had:	Y	N	Age of onset
Has anyone ever touched you or forced you to have sex against your will?				Heart disease/attacks before age 50? mother/father/brother/sister			
Is verbal abuse or physical fighting making you feel unsafe at home?				Stroke? mother/father/brother/sister			
Have you ever been diagnosed & treated for an eating disorder?				High blood pressure? mother/father/brother/sister			
Do you exercise? type _____ frequency _____ amt _____				Cancer? mother/father/brother/sister			
Do you use tobacco? Frequency/amount: _____ How long: _____				Diabetes? mother/father/brother/sister			
Do you use alcohol? Frequency/amount: _____				Alcohol/drug use problems? Mother/father/brother/sister			
Do you use recreational/street drugs? Type/frequency/amount: _____				Mental health problems? Mother/father/brother/sister			
Last grade or level of school completed: _____				Did your mother take DES when pregnant with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				CURRENT SYMPTOMS OR CURRENT CONCERNS			
				Do you currently have any of the following?	Y	N	
				Vaginal discharge, itching, bumps, warts, sores?			
				Pelvic pain?			
				Pain or burning when urinating?			
				Pain during sex?			
REPRODUCTIVE HEALTH HISTORY							
Have you ever had the following? If so, when?	Y	N	When	Vaginal spotting/bleeding after sex?			
Abnormal pap smear				Concerned you might be pregnant?			
Colposcopy or biopsy of the cervix				Have you had sex without birth control or without using a condom since your last menstrual period?			
Breast biopsy or other breast procedures				STD & HIV RISK HISTORY			
Tubal pregnancy				Age when you first had sex _____			
Pelvic infection (PID)				Do you have sex with: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both			
Sexually transmitted infections				Number of sexual partners in the last: 3 mos ____ 6 mos ____ 12 mos ____			
Recurrent vaginal infections				New sex partner in the last two months <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Are you interested in STD screening? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Are you interested in HIV screening? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you nursing a baby now?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Does your sexual partner(s) :			
Date of last pap smear: _____	<input type="checkbox"/> Never had			Have a history of use, or currently inject drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of last breast exam: _____	<input type="checkbox"/> Never had			Had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what yr _____?			
				Have, or ever had, a STD? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Have HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Have other sex partner(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Have sex with: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both			
				Use condoms? <input type="checkbox"/> Yes <input type="checkbox"/> No			
MENSTRUAL HISTORY				INTERVIEWER'S COMMENTS			
Age at first period _____							
Date of last normal period _____							
Usual number of days between periods _____							
Vaginal spotting/bleeding between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Is your menstrual flow: ___light ___moderate ___heavy							
Are your cramps: ___mild ___moderate ___severe ___none							
I consent to receive medical care for family planning services by professionally licensed staff of this agency. I understand this may include physical examination, laboratory testing and prescriptions. I have the right to ask questions about my care, participate in the plan for my care, and to refuse services at any time.							

Client: _____ Interviewer: _____ Date: _____

PCN: