

State of Alaska  
 Department of Health and Social Services  
 Section of Public Health Nursing  
**Female Reproductive Health History**

Family Planning clinic services are confidential. No information is released without your consent except as may be required under public health and safety laws. You will be advised of any such reporting if it occurs. Information used for evaluation and planning purposes never includes personal identifiers.

Your age ___ Student <input type="checkbox"/> No <input type="checkbox"/> Yes School Attended _____ Highest level of education completed _____ Your occupation _____							
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Living with Partner							
Medical Home - Name of Health Care Provider or Clinic _____				Date last seen _____			
Dental Home - Name of Dentist or Dental Clinic _____				Date last seen by Dentist _____		Date last seen by Dental Hygienist _____	
<b>Your Personal Health History</b>							
Any allergy to medicines and/or foods? <input type="checkbox"/> No <input type="checkbox"/> Yes				Any allergy to latex? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know			
List all medicines and foods you are allergic to and the reaction type _____							
Are you taking any prescription medicines, over-the-counter medicines, vitamins and/or supplements now? <input type="checkbox"/> No <input type="checkbox"/> Yes							
Please list _____							
Have you ever been hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes Reason _____							
Have you ever had surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes Reason _____							
Have you ever had a blood transfusion? <input type="checkbox"/> No <input type="checkbox"/> Yes Reason _____							
Have you had all required Alaska School shots (vaccinations)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know							
If you were born before 1972, did your mother take diethylstilbestrol (DES) when pregnant with you? <input type="checkbox"/> NA <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know							
<b>Please check 'Yes' for any condition listed below that you have now or had in the past, and please check 'No' if you 'never' had</b>							
<b>Head &amp; Neck</b>	No	Yes	Additional Details or Comments	<b>Gastrointestinal system</b>	No	Yes	Additional Details or Comments
Thyroid condition				Gallbladder disease			
Other				Inflammatory bowel disease			
<b>Breasts</b>	No	Yes		<b>Abdomen</b>	No	Yes	
Lump or mass				Severe abdominal pain			
Nipple discharge				Hernia			
Pain				<b>Genital-Urinary</b>	No	Yes	
Implants				Repeat urinary tract infection			
Reconstructive surgery				Kidney disease			
<b>Skin</b>	No	Yes		Repeat vaginal infection			
Rash/bumps/sores/warts				Recurring pelvic pain			
Acne				<b>Neurological system</b>	No	Yes	
Tattoo(s)				Seizure disorder			
Body piercing(s)				Vision changes, blind spots			
<b>Skeletal System</b>	No	Yes		Headaches with vision changes, tingling or numbness			
Fractures "broken bones"							
Osteoporosis "bone loss"							
<b>Heart &amp; circulatory system</b>	No	Yes		<b>Miscellaneous</b>	No	Yes	
Blood clots in <input type="checkbox"/> lungs <input type="checkbox"/> legs				Active Liver Disease <input type="checkbox"/> Tumor <input type="checkbox"/> Cirrhosis			
High blood pressure				Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			
Stroke				Diabetes Type 1 Type 2			
Heart attack				Diabetes during pregnancy			
Heart disease				Cancer			Type?
Heart murmur				Asthma			
Anemia "low iron"				Autoimmune disease			Type?
High cholesterol				Tuberculosis			
HR # _____  Name _____  B. Date _____ Sex _____ Race _____  Residence _____  Facility _____  Date _____ Time _____	Interviewer Comments (Please include initials, title and date)						

Social and Lifestyle History				No	Yes	Family History				No	Yes	Age of Onset
Do you exercise? Type _____ How often _____						Have your <b>immediate</b> family members had? Heart disease or attacks? <input type="checkbox"/> Before age 50 Mother / father / brother / sister						
Do you wear ? <input type="checkbox"/> seatbelts <input type="checkbox"/> helmets <input type="checkbox"/> life vests						Blood clots in legs or lungs? Stroke? mother / father / brother / sister <input type="checkbox"/> Age _____						
Has anyone ever touched you in a way that made you feel uncomfortable or forced you to have sex against your will?						High blood pressure needing medication mother / father / brother / sister						
Is verbal abuse or physical fighting making you feel unsafe at home?						Cancer Type _____ mother / father / brother / sister						
Do you, family or friends have concerns about your? <input type="checkbox"/> body weight <input type="checkbox"/> eating habits / diet <input type="checkbox"/> nutritional intake						Diabetes Type 1 Type 2 Age _____ mother / father / brother / sister						
Do you have feelings of sadness, fatigue, and/or anxiety that affect your ability to enjoy daily activities?						Mental Health Concerns? mother / father / brother / sister						
Do you have thoughts of harming yourself or others?						Alcohol/drug use <input type="checkbox"/> Past <input type="checkbox"/> Present mother / father / brother / sister						
Do you use tobacco? Type? Amount and frequency of use? _____						<b>STD and HIV Risk History</b>						
How frequently do you use alcohol? type _____ frequency _____ amount _____						Are you currently having sex?		No	Yes	<input type="checkbox"/> oral <input type="checkbox"/> vaginal <input type="checkbox"/> anal		
Do you use any recreational/street drugs? type(s) _____ frequency _____ amount _____						Have you had a new sexual partner in the last 2 months?						
Did you use a condom during your last sexual encounter?												
<b>Menstrual History</b>						Your frequency of condoms use? <input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Always						
Age at first menstrual period _____						Number of sexual partners in the last 6 mos _____ 12 mos _____						
First day of last normal period _____						Last Chlamydia screen. Date _____ <input type="checkbox"/> Never had screening						
Usual number of days between periods _____						Last HIV Screen. Date _____ <input type="checkbox"/> Never had screening						
Vaginal spotting or bleeding between periods <input type="checkbox"/> Yes <input type="checkbox"/> No						Do you have sex with <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both						
Menstrual flow is <input type="checkbox"/> Spotting <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy						What are you doing to protect yourself from STI and HIV _____						
Menstrual cramps are <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe						<b>Questions About Your Sexual Partner</b>			No	Yes	Don't know	
Does your sex partner?												
<b>Reproductive Health History</b>						Use a condom						
Have <b>you</b> ever had any of the following? If so, what and when?				No	Yes	When	Now have or ever had a STD					
Sexually transmitted infections <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis							Now have signs or symptoms of an STD					
Recurrent vaginal infections							Have HIV infection					
Ovarian Cyst(s)							Currently injects drugs or history of use					
Endometriosis							Currently or previously has exchanged money or drugs for sex					
Uterine Fibroids							Have other sex partners					
Pelvic Infection (pelvic inflammatory disease)							Had a blood transfusion? Year _____					
Tubal "ectopic" pregnancy							Have sex with <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both Male and Female <input type="checkbox"/> Don't know					
<b>Your Current Concerns or Symptoms</b>						Do you have any of the following?						
Abnormal pap smear							No	Yes	Comments			
Colposcopy with cervical biopsy							Concern now about an unplanned pregnancy					
Procedures on the cervix for abnormal cells <input type="checkbox"/> Cryo <input type="checkbox"/> LEEP <input type="checkbox"/> Cone Biopsy <input type="checkbox"/> Other							Last sex without birth control or condom Date _____					
Mammogram screening							Vaginal discharge					
Breast biopsy or other breast procedures							Rash, bumps, warts, sores, itching					
Breast cancer with treatment							Burning or pain when urinating					
							Pelvic pain					
							Pain during sex					
Total number: Pregnancies _____ Full term births _____ Preterm births _____ Miscarriages _____ Abortions _____ AGE at first pregnancy _____							Vaginal spotting/bleeding after sex					
							Breast feeding infant now					
<b>Pre-Conception Health Planning</b>												
Are you planning a pregnancy in the next 6-12 months? <input type="checkbox"/> Unsure <input type="checkbox"/> No <input type="checkbox"/> Yes												
Have you had problems getting pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, have <b>not</b> been able to get pregnant after 12 months of seeking pregnancy												
What method(s) of birth control have you used in the <b>past</b> ? <input type="checkbox"/> Pills <input type="checkbox"/> Shot <input type="checkbox"/> Patch <input type="checkbox"/> Ring <input type="checkbox"/> Implant <input type="checkbox"/> IUD <input type="checkbox"/> Condoms <input type="checkbox"/> Abstinence												
Which of these methods did you like <b>best</b> ? <input type="checkbox"/> Pills <input type="checkbox"/> Shot <input type="checkbox"/> Patch <input type="checkbox"/> Ring <input type="checkbox"/> Implant <input type="checkbox"/> IUD <input type="checkbox"/> Condoms <input type="checkbox"/> Abstinence												
What method(s) have you used in the past <b>month</b> ? <input type="checkbox"/> Pills <input type="checkbox"/> Shot <input type="checkbox"/> Patch <input type="checkbox"/> Ring <input type="checkbox"/> Implant <input type="checkbox"/> IUD <input type="checkbox"/> Condoms <input type="checkbox"/> Abstinence												
What birth control methods are you interested in starting or continuing during this visit? <input type="checkbox"/> Pills <input type="checkbox"/> Shot <input type="checkbox"/> Patch <input type="checkbox"/> Ring <input type="checkbox"/> Implant <input type="checkbox"/> IUD <input type="checkbox"/> None												
Are you interested in learning more about what you can do to plan for a healthy pregnancy in the future? <input type="checkbox"/> No <input type="checkbox"/> Yes												
Is there anything else you would like us to ask or know about your health? <input type="checkbox"/> No <input type="checkbox"/> Yes What _____												
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 including STD/HIV screening, and prescriptions. I have the right and will be provided with the opportunity to ask questions about my care, participate in the plan for my care, and to refuse services at any time without penalty.												

Client Signature \_\_\_\_\_ Interviewer Signature/Title \_\_\_\_\_ Date \_\_\_\_\_