FAMILY PLANNING ASSOCIATES MEDICAL GROUP

PATIENT HISTORY

Date _____

First Name _____ Last Name _____ Birth Date _____

Pronouns (check/write in any that you use): ❒ she/her ❒ they/them ❒ he/him **OR** _____ Age_____

Legal Name(if different) _____ Phone (_____) _____

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

Patient's Medical History

❒ Yes ❒ NO - Asthma
❒ Yes ❒ NO - High Blood Pressure
❒ Yes ❒ NO - Heart Disease
❒ Yes ❒ NO - Blood Clots in Veins
❒ Yes ❒ NO - Diabetes
❒ Yes ❒ NO - Liver Disease
❒ Yes ❒ NO - Kidney Problems
❒ Yes ❒ NO - Bladder Problems
❒ Yes ❒ NO - Hepatitis
❒ Yes ❒ NO - Cancer
❒ Yes ❒ NO - Thyroid Problems
❒ Yes ❒ NO - Tuberculosis
❒ Yes ❒ NO - Bleeding Disorders

❒ Yes ❒ NO - Sickle Cell Anemia
❒ Yes ❒ NO - Anemia
❒ Yes ❒ NO - Seizures
❒ Yes ❒ NO - Headaches
❒ Yes ❒ NO - Dizziness
❒ Yes ❒ NO - Vision Problems
❒ Yes ❒ NO - Body/Facial Piercing(s)
❒ Yes ❒ NO - Severe Depression
❒ Yes ❒ NO - Anesthesia Problems (List below)
❒ Yes ❒ NO - Malignant Hyperthermia (List below)
❒ Yes ❒ NO - C-Sections (List Years and Reasons):
_____
❒ Yes ❒ NO - Allergies (List all Foods, Meds, Latex):
_____

❒ Yes ❒ NO - PID (Pelvic Inflammatory Disease)
❒ Yes ❒ NO - Vaginal Infections
❒ Yes ❒ NO - Have You Had A Pap Smear?
_____ (What Year?)
❒ Yes ❒ NO - Abnormal Pap
❒ Yes ❒ NO - Breast Lumps
❒ Yes ❒ NO - Sexually Transmitted Infection:
_____
❒ Yes ❒ NO - Other Medical Problems:
_____
_____
_____
_____
_____

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	
❒	❒	Stroke	❒	❒	High Blood Pressure
❒	❒	Heart Disease	❒	❒	Anesthesia Problems

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? (Check one) ❒ Heavy ❒ Moderate ❒ Light

Birth Control History

What method(s) have you tried? (☑ all that apply):

❒pill ❒patch ❒ring ❒shot ❒IUD ❒implant ❒cervical cap ❒diaphragm
❒condom ❒spermicide ❒fertility awareness ❒withdrawal ❒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:

❒ OK for any BC Rx ❒ Micronor/Depo only
❒ None ❒ Needs 35+ Form ❒ if BP < 140/90
❒ _____

_____

FPA: PA /APN/ MD Signature

Patient History 04-2024