

Central Montana Family Planning Comprehensive Health History

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Improving the health of our communities.

Patient Name: _____

Date of Birth: ____/____/____

Primary Care Provider: _____

Please list any prescriptions or over the counter medicines you are currently taking:

Please list any medicines, foods, latex, etc. that you are allergic to and the reaction you have from them:

MEDICAL

Have you had any of the following?	Y	N	Staff Notes
ER or hospitalization in the last year- if yes, please list reason and date(s):			
Surgeries- if yes, please list type(s) and date(s):			
Cancer- if yes, please list type(s) and date(s):			
Eye problems (excluding contacts or glasses)			
Hearing problems			
Heart disease, heart murmur and/or high blood pressure			
High cholesterol and/or triglycerides			
Blood clots in your arms, legs or chest			
Heart attack or stroke			
Breathing problems and/or Asthma			
Breast lumps and/or nipple discharge			
Tuberculosis and/or been exposed to it			
Stomach and/or bowel problems			
Colonoscopy- if yes, please list most recent date(s):			
Gallbladder disease			
Liver disease (i.e. hepatitis, mono, jaundice, cirrhosis, etc.)			
Kidney and/or bladder problems			
Burning with urination and/or blood in urine			
Arthritis and/or Osteoporosis			
Gout			
Acne and/or other skin problems- if yes, please list:			
Thyroid problems			
Diabetes			
Migraines and/or frequent headaches			
Epilepsy and/or convulsions			
Blood problems (i.e. sickle cell anemia, hemophilia, low iron, etc.)			
You and/or your partner(s) had a blood transfusion, tissue or organ transplant or artificial insemination			

FAMILY

Have your grandparents, parents and/or siblings had any of the following? If "yes", please note who and age of occurrence.	Y	N	Staff Notes
Blood clots			
Bleeding problems			
High blood pressure			
High cholesterol and/or triglycerides			
Breast, ovarian, uterine, colon or other cancers			

Have your grandparents, parents and/or siblings had any of the following? If "yes", please note who and age of occurrence.	Y	N	Staff Notes
Heart attack			
Stroke			
Diabetes			
Birth defects and/or genetic disorders			
Alcohol and/or drug abuse			
Mental health disorders			
Physical and/or sexual abuse			

PERSONAL

Please answer the following to the best of your ability.	Y	N	Staff Notes
Do you use any form of tobacco/nicotine- if yes, how often and which form(s):			
Do you drink alcohol- if yes, how often and amount per time:			
Do you use marijuana- if yes, how often:			
Do you use an illegal drug or prescription drug for nonmedical reasons- if yes, how often:			
Do you have any concerns, fears or anxieties we should be aware of			
Do you experience depression and/or other mental health issues			

IMMUNIZATIONS

Have you received the following vaccinations?	Y	N	Staff Notes
Measles, Mumps, Rubella (MMR)			
Tetanus, Diphtheria, Pertussis (Tdap)			
Hepatitis A			
Hepatitis B			
Varicella (Chicken Pox)			
Human Papilloma Virus (HPV)			
Meningococcal B			

SEXUAL

Have you ever tested positive for:	Y	N	Staff Notes
Chlamydia and date(s):			
Gonorrhea and date(s):			
Genital Warts or HPV and date(s):			
Syphilis and date(s):			
Herpes Type 1 and date:			
Herpes Type 2 and date:			
Trichomoniasis and date(s):			



Please answer the following to the best of your ability.	Y	N	NA	Staff Notes
Have you been tested for HIV- if yes, most recent date and results:				
Do you have sexual partner(s) with positive HIV				
Have you and/or your sexual partner(s) used needles for drugs				
Have you and/or your sexual partner(s) exchanged sex for drugs or money				
When did you last have sex:				
You and your partner(s) have: ☐ anal sex ☐ oral sex ☐ vaginal sex				
Do you have condomless sex				
Have you had a new sexual partner in the past 2 months				
Does your sexual partner(s) have other partners				
Number of sexual partners in the past 2 months:				
Number of sexual partners in the past 12 months:				
Gender(s) of sexual partner(s): ☐ male ☐ female ☐ both ☐ transman ☐ transwoman ☐ intersex ☐ other				
Please list your method of contraception used to avoid pregnancy				
Have you experienced problems with a birth control method- if yes, which method(s):				
Have you had sex without any birth control (including condoms) since your last period				
If yes, has this date been within the last 7-10 days				
If yes, has this date been within the past 72-hours				

**COMPLETE IF YOU ARE MALE ASSIGNED
AT BIRTH OR MALE-TO-FEMALE**

Please answer the following to the best of your ability.	Y	N	NA	Staff Notes
Do you have abnormal discharge from the penis				
Are you circumcised				
Do you have a lesion, sore and/or lump on scrotum or testicles- if yes, when and please describe:				
Do you have pain and/or other issues associated with sex- if yes, please describe:				
Have you had gender transition surgery- if yes, please describe:				
Do you have children- if yes, how many:				
Do you plan to have children- if yes, when: ☐ now ☐ 1-2 years ☐ 3-5 years ☐ 5+ years ☐ unsure				
What method of contraception do you use to avoid pregnancy? ☐ condoms ☐ vasectomy ☐ abstinence ☐ rely on partner's method:				

**COMPLETE IF YOU ARE FEMALE ASSIGNED
AT BIRTH OR FEMALE-TO-MALE**

Please answer the following to the best of your ability.	Y	N	NA	Staff Notes
Age when you had your first period:				
First day of most recent period:				
Was this period normal- if no, please describe:				
Do you have a period every month				
Your typical flow is: ☐ light ☐ medium ☐ heavy				
Do you bleed between periods				
Do you have cramps with your period				
Do you take medication for cramps- if yes, what do you take:				
Do you plan to have children- if yes, when: ☐ now ☐ 1-2 years ☐ 3-5 years ☐ 5+ years ☐ unsure				
How many times have you been pregnant:				
Dates you gave birth:				
Number of living children:				
Miscarriage and/or abortion date(s):				
Tubal pregnancy date(s):				
Currently breastfeeding				
Baby that weighed less than 5½ pounds				
Baby that weighed more than 9 pounds				
Pregnancy with high blood pressure, diabetes and/or a baby with birth defects				
Have you ever had a Pap smear				
Have you ever had an abnormal Pap smear- if yes, please list results and date(s):				
Did you receive treatment for an abnormal Pap smear- if yes, please list treatment type and date(s):				
Follow-up Pap smears were: ☐ normal ☐ abnormal ☐ not done				
Date of last Pap smear:				
Have you had a mammogram and/or breast ultrasound- if yes, please list results and date(s):				
History of ovarian problems- if yes, please list:				
History of uterine problems and/or uterine fibroids- if yes, please list:				
History of Pelvic Inflammatory Disease (PID)- if yes, please list:				
Do you have pain or other issues associated with sex- if yes, please describe:				
Do you currently have vaginal discharge that itches, burns or a bad odor				
Have you had gender transition surgery- if yes, please describe:				

PATIENT SIGNATURE: _____

DATE: ____/____/____

STAFF SIGNATURE: _____

DATE: ____/____/____