



**FAMILY PLANNING ASSOCIATES MEDICAL GROUP
PATIENT HISTORY**

Name _____ Date _____

Birth Date _____ Age _____ Message Phone () _____

In the event of an emergency or abnormal lab results, we make all reasonable efforts to contact you.

**Patient's Medical History (NOT FAMILY HISTORY)
Check "YES" if you have ever had any of the following:**

- | | | |
|---|--|--|
| YES | YES | YES |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> PID (Pelvic Inflammatory Disease) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Have You Had A Pap Smear? |
| <input type="checkbox"/> Blood Clots in Veins | <input type="checkbox"/> Headaches | _____ (Year) |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Abnormal Pap |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Breast Lumps |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Piercings: Facial/Oral/Body (circle) | <input type="checkbox"/> Sexually Transmitted Disease: |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Severe Depression | _____ |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Anesthesia Problems (List below) | <input type="checkbox"/> Other Medical Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Malignant Hyperthermia (List below) | (List below) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> C-Sections (List Years and Reasons) | _____ |
| <input type="checkbox"/> Thyroid Problems | _____ | _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Allergies (List all Foods, Meds, Latex) | _____ |
| <input type="checkbox"/> Bleeding Disorders | _____ | _____ |

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 strength 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? _____

Family Medical History

Has anyone in your immediate family ever had:

- | | |
|--|---|
| YES | YES |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Problems with Anesthesia |

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? Heavy Moderate Light **(Circle one)**

PATIENT TO COMPLETE:

What methods of birth control have you used? _____

What problems did you have with these methods? _____

What method are you using now? _____

What method would you like to use now? _____

FPA STAFF TO COMPLETE:

CHC OK Yes No
 Needs 35 and Older Form

FPA: NP PA CNM MD

MD/NP/PA/CNM Signature: _____
FPA PH012 Revised April 2008 ker