FAMILY PLANNING ASSOCIATES MEDICAL GROUP, LTD
PATIENT HISTORY

First Name __________________________ Last Name ___________________________________Date________________

Birth Date _______________________ Age _______ Message 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		YES	NO		YES	NO	
❒	❒	**Asthma**	❒	❒	Sickle Cell Anemia	❒	❒	PID (Pelvic Inflammatory Disease)
❒	❒	High Blood Pressure	❒	❒	Anemia	❒	❒	Vaginal Infections
❒	❒	Heart Disease	❒	❒	Seizures	❒	❒	Have You Had A Pap Smear?
❒	❒	Blood Clots in Veins	❒	❒	Headaches			_______________ (What Year?)
❒	❒	Varicose Veins	❒	❒	Dizziness	❒	❒	Abnormal Pap
❒	❒	Diabetes	❒	❒	Vision Problems	❒	❒	Breast Lumps
❒	❒	Liver Disease	❒	❒	Body/Facial Piercing(s)	❒	❒	Sexually Transmitted Disease:
❒	❒	Kidney Problems	❒	❒	Severe Depression			________________________
❒	❒	Bladder Problems	❒	❒	Anesthesia Problems (List below)	❒	❒	Other Medical Problems:
❒	❒	Hepatitis	❒	❒	Malignant Hyperthermia (List below)			______________________________
❒	❒	Cancer	❒	❒	C-Sections (List Years and Reasons):			______________________________
❒	❒	Thyroid Problems			_______________________________			______________________________
❒	❒	Tuberculosis	❒	❒	Allergies (List all Foods, Meds, Latex):			______________________________
❒	❒	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 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? (Circle one) Heavy Moderate Light

Birth Control History

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

❒pill, ❒patch, ❒ring, ❒shot, ❒IUC, ❒implant, ❒cervical cap, ❒diaphragm, ❒condom, ❒spermicide, ❒fertility awareness, ❒withdrawl, ❒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

❒____

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FPA: PA /APN/ MD Signature