FAMILY PLANNING ASSOCIATES MEDICAL GROUP

Patient First Name & ID Number _____ Age _____

State and Zip Code _____Phone Number _____

Do you prefer: ❒ Text ❒ Phone Call Can we leave voice mail? ❒ No ❒ Yes

Who should we say is calling? ❒ Family Planning Assoc. ❒ Dr's Office ❒ A friend (staff will use their first name)

Appt Type: ❒ Medication ❒ 1 Day In-Office Procedure ❒ 2-3 Day In-Office Procedure

Appt Date/Time_____

First Day of Your Last Period or Ultrasound details _____

Tell us about your Pregnancy History: How many times have you been pregnant, including this pregnancy? _____

Vaginal Births: _____C-Sections: _____Abortions: _____ Miscarriages: ____ Stillbirths: ____ Ectopic/Molar: _____

Did you have any problems during any of these pregnancies? ❒ NO ❒ YES, Please explain: _____

_____

Have you ever had any of the following medical concerns or diagnosis?

YES	NO		YES	NO		YES	NO	
❒	❒	High Blood Pressure	❒	❒	Heart Disease	❒	❒	Blood Clots in Veins
❒	❒	Vision Problems	❒	❒	Liver Disease	❒	❒	Kidney Problems
❒	❒	Bladder Problems	❒	❒	Hepatitis	❒	❒	Severe Depression
❒	❒	Bleeding Disorders	❒	❒	Sickle Cell Anemia	❒	❒	Anemia
❒	❒	Tuberculosis	❒	❒	Cancer	❒	❒	Diabetes
❒	❒	Headaches	❒	❒	Body/Facial Piercing(s)	❒	❒	Dizziness

YES NO – IF YES, PLEASE EXPLAIN

❒ ❒ Have you ever seen a heart/lung doctor? _____

❒ ❒ Surgery/Hospitalization History: _____

❒ ❒ Serious Injuries: _____

❒ ❒ Current Sexually Transmitted Infection(s): _____

❒ ❒ PID (Pelvic Inflammatory Disease), if yes, when? _____

❒ ❒ Thyroid Problems, if yes, when where your last labs? _____

❒ ❒ Anesthesia Problems: _____

❒ ❒ Malignant Hyperthermia: _____

❒ ❒ Has anyone in your immediate family ever had anesthesia problems? _____

❒ ❒ Allergies, if yes list all food, medications, latex, etc: _____

❒ ❒ Have you ever used recreational drugs, if yes when & what drug(s)? _____

❒ ❒ Do you drink alcohol, if yes, how often & how much? _____

❒ ❒ Allergies, if yes list all food, medications, latex, etc: _____

_____

❒ ❒ Do you currently take any medications, herbs, diet pills, or vitamins, if yes, what dosage and when, or write "unknown":

_____

❒ ❒ Do you have any medical problems not listed above? _____

_____