## Name \_\_\_\_\_ FAMILY PLANNING HISTORY

A. REV	IEW OF SYSTEMS	A. RE\	/IE\	N OF SYSTEMS (cont.)		
YES 1	NO GENERAL	YES I	NO	ENDOCRINE		
	1. My health is generally good			46. Thyroid problems	•	
	2. Night sweats/hot flashes			47. Diabetes		
	3. Cancer. If yes, where/when?			HEMATOLOGICAL/LYMPHATIC		
	4. Smoke cigarettes. If yes, how many per day?			48. Anemia		
	5. Alcohol use. If yes, how many drinks/week?			49. Sickle cell disease/trait	-	
	Birth defects or genetic problems			50. Blood clotting disorder		
	o. Birtir delects of genetic problems					
	7.4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_		ALLERGY/IMMUNOLOGY		
	7. Are you being treated for any illness/condition now?			51. Lupus		
	If yes, what?			52. Ever had Rubella? (German measles)		
				53. Have you had all your childhood Im		ns
	8. Do you currently take medicine:			54. Tetanus shot in last 10 years? Date:		
	□ prescription □ over the counter □ herbal?			55. Have you completed Hep B Series Y	res No	
	If yes, name:			56. Have you had the HPV vaccine for ce	rvical canc	er?
	EYES			57. Are you allergic to any drug, medicat	ion. latex o	or
	10. Eye problems (except glasses or contacts)			other substance, including local anesthes		
	EAR/NOSE/MOUTH/THROAT			i	<b>,</b> ,	
	11. Hearing problems	$\neg$			-	
	12. Frequent nosebleeds	R HO	GDI.	TALIZATION AND SURGERIES		
	CARDIOVASCULAR	Year	JF1	Reason		
		Teal		neason	<del></del>	1
	13. Mitral Valve Prolapse	-				
	14. Heart murmur	-				
	15. Varicose veins					
	16. Blood clots (head/leg/lungs)	C. FAMILY HISTORY				
	17. Stroke or stroke-like problems	Are yo	u a	dopted? □ Yes □ No		
	18. High blood pressure	Have y	our/	parents, brothers, or sisters had any of	the following	ng?
	19. High Blood Pressure requiring treatment			•		· ·
	20. High Cholesterol	YES	NO	Diagnosis	B∉	elative
	RESPIRATORY			Osteoporosis		
	21. Chronic cough or other breathing problems/asthma			Diabetes	+	
	22. Tuberculosis or exposure to tuberculosis			Heart attack/stroke before age 50	+	
	GASTROINTESTINAL			High blood cholesterol or fats	+	
	23. Stomach or bowel problems			High blood cholesteror or lats	+	
	24. Liver problems (hepatitis or tumor, etc.)	-		Genetic problems	+	
					+	
	25. Gallbladder problems GENITOURINARY			Blood clots/clotting disorder	+	1
		$\neg$ $\vdash$ $\vdash$		Cancer: If yes, type:	+	1
	26. Bladder or kidney problems					
	27. Uterine fibroids					
	28 Ovarian cysts	STAFF	CC	DMMENTS / EXPLANATIONS (by number	r)	
	29. Breast lump or discharge					
	30. Last Mammogram (breast X-Ray) Date:					
	31. Vaginal discharge that itches/burns or has a bad odor					
	32. Endometriosis					
	33. Pain with sex			-		
	34. Previous abnormal pap			-		
	35. Last PAP Date:					
	36. Did your mother take DES when she was pregnant				-	
	with you? (If born before 1975)	-				
	37. History of sexually transmitted infection. Check type:	_				
	, , , , , , , , , , , , , , , , , , , ,					
	□ chlamydia □ gonorrhea □ genital warts □ herpes					
	□ syphilis □ PID □ Hepatitis B □ HIV □ Other					
	38. Your age at first vaginal intercourse. AGE:					
	MUSCULOSKELETAL					
	39. Arthritis or osteoporosis					
	SKIN					
	40. Acne or other skin problems. What?					
	NEUROLOGICAL					
	41. History of Migraine headaches with vision changes?					
	42. Seizures/epilepsy			Label # 5		
	43. Numbness in arms/legs (recurring)					
	PSYCHOLOGICAL					
	44. Depression - requiring treatment					
	45 Suicide thoughts and/or plane?					