State of Alaska
Department of Health and Social Services
Section of Public Health Nursing

Female Reproductive Health History

Family Planning Clinic services are confidential. No information is released without your consent except as may be required under public health and safety laws. You will be advised of any such reporting if it occurs. Information used for evaluation and planning purposes never includes personal identifiers.

Your age _____ Student ☐ No ☐ Yes School attending _____ Highest grade completed _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner Your occupation

Name of your Health Care Provider or Clinic Date last seen

Have you seen a Dentist in the past year ☐ Yes ☐ No

What is the reason for your visit today?

Your Personal Health History

	No	Yes	List	What was the reaction?
Allergy to medications?				
Other allergies?				
Allergy to latex?				
Are you taking any prescription, or over the counter medications, vitamins and/or supplements?				
Have you ever been hospitalized?				
Have you ever had surgery?				

Please check box **C** ***Current*** *(if you currently have)* or **P** **for** ***Past*** (if you have ever had) any of the following Medical Conditions

	C	P		C	P		C	P		C	P
Diabetes ☐ Type 1 ☐ Type 2			Blood clot ☐ legs ☐ lungs			Hepatitis Type ☐ A ☐ B ☐ C			☐ Tubal ☐ Molar pregnancy		
Thyroid condition			Blood clotting disorder			HIV / AIDS			Severe abdominal pain		
Breast ☐ mass ☐ biopsy ☐ surgery			Heart ☐ disease ☐ attack			Genital Herpes			Severe pelvic pain		
Breast ☐ pain ☐ nipple discharge			High cholesterol			Syphilis			Sore throat		
Uterine ☐ fibroids ☐ abnormality			Cholestasis			Gonorrhea			Headaches		
Unexplained vaginal bleeding			Gallbladder disease			Chlamydia			Seizure disorder		
Abnormal pap smear			Kidney disease			Other STI's			Rheumatoid arthritis		
Cancer (types)			Inflammatory bowel disease			Skin: ☐ rash ☐ bumps ☐ sores			Lupus		
Anemia "low iron"			Bariatric surgery			PID (Pelvic Infection)			Multiple sclerosis		
High blood pressure			Hernia			Swollen lymph nodes			Tuberculosis		
Stroke			Liver problems ☐ Tumor ☐ Cirrhosis			Problems with urination ☐ pain ☐ burning			Exposure to environmental ☐ hazards ☐ toxins		

☐ I have no current or past medical conditions Other medical conditions not listed above:

Family History

(please put an X in the boxes for family members if they have or have had the following medical conditions, please describe in comment box)

Medical Condition	Mother	Father	Sister	Brother	Comments
Blood clot in ☐ legs or ☐ lungs					
Cancer: **Type** (write under comments)					
Mental Health Concerns ☐ Past ☐ Present					
Problems with Alcohol ☐ Past ☐ Present					
Problems with drugs ☐ Past ☐ Present					

☐ My family has none of the above conditions ☐ I don't know my family history: ☐ adopted ☐ not living with parents ☐ other

HR # _____

Name _____

Birth Date _____ Sex _____

Residence _____

Facility _____

Date _____

Interviewer updates (include date, name & credentials)

Reproductive Health History

Total Number: Pregnancies _____ Full term births _____ Preterm births _____ Miscarriages _____ Abortions _____ Living children _____

Last Delivery (date) _____ ☐ Vaginal ☐ C-section Currently breast feeding? ☐ Yes ☐ No Date of last pap smear _____

Age of first period _____ Vaginal spotting between periods ☐ No ☐ Yes First day of last period _____ Usual number of days between periods _____

Periods last _____ (days) Menstrual flow is ☐ Spotting ☐ Light ☐ Moderate ☐ Heavy Menstrual cramps are ☐ None ☐ Mild ☐ Moderate ☐ Severe

Comments:

Preconception Health Planning

Are you planning a pregnancy in the next 6-12 months? ☐ No ☐ Yes Have you had problems getting pregnant? ☐ No ☐ Yes ☐ Haven't tried

Put a X under methods when answering questions	Pills	Shot	Patch	Ring	IUD	Implant	Condom	Withdrawal	Natural	Sterilization	Abstinence	None
What method(s) have you used in the **past**?												
What method(s) have you used in the past ***month***?												
What method(s) did you like the **best?**												
What method are you most **interested in** at this visit?												

Social and Lifestyle History

	No	Yes		No	Yes
Do you use tobacco? Type(s)_____Amount per day_____			Do you have feelings of sadness, fatigue and/or anxiety that affect your ability to enjoy daily activity?		
Do you drink alcohol? Type(s)_____ Amount_____ Frequency_____			Do you have thoughts of harming yourself or others?		
Do you use any recreational/street drugs? Type (s)_____ Amount _____ Frequency _____			Is verbal abuse or physical fighting making you feel unsafe?		
Do you wear ☐ seatbelts ☐ helmets ☐ life vests			Has anyone ever touched you in a way that made you feel uncomfortable or forced you to have sex against your will?		

Comments:

Sexual History

Questions about **You**	No	Yes	Questions about **Your Sexual Partner(s)**	No	Yes	Unsure
Are you currently sexually active or in a sexual relationship?			Use a condom?			
Have you had a **new** sexual partner in the last 2 months?			Currently has or ever had a STI?			
Did you use condoms during your last sexual encounter?			Currently has symptoms of a STI?			
Currently or previously traded sex for money, drugs or alcohol?			Currently or previously traded sex for money, drugs or alcohol?			
Have sex with ☐ Male ☐ Female ☐ Both Type of sex ☐ Oral ☐ Anal ☐ Vaginal			Currently or previously injected drugs?			
How often do you use a condom? ☐ never ☐ sometimes ☐ always			Currently have sex with other partners? If yes ☐ Male ☐ Female ☐ Both ☐ Unsure			
Number of sexual partners in the past 12 months _____ 2 months _____ 1 month _____			Partners **past** partners include: ☐ Male ☐ Female ☐ Both ☐ None ☐ Unsure			

Comments:

Is there anything else you want us to know about your current or past medical / social or sexual history? ☐ No ☐ Yes (If yes, please explain)

Do you have any concerns you want to discuss today? ☐ No ☐ Yes (If yes, please explain)

Additional Interviewer updates (include date, name & credentials)

I consent to receive medical care for sexually transmitted infections and/or family planning services by professionally licensed staff of this Agency. I understand that this may include a physical examination, laboratory testing including STI/HIV screening, and prescriptions. I have the right to participate in my care, ask questions and refuse services at any time without penalty.

Client Signature _____Date _____ Interviewer's Signature/Credentials _____ Date_____