

Camelback Family Planning

Name: _____

DATE: _____

Date of Birth: _____

HEALTH HISTORY

Your medical records are strictly confidential and will not be released without your written consent. Your complete and honest health history is necessary to provide you with the best medical care.

GENERAL HEALTH HISTORY

Do you have any medical allergies? Reaction to Novocain?

NO YES Explain: _____

Have you ever had a reaction to anesthesia?

NO YES Explain: _____

Are you currently under medical treatment?

NO YES Explain: _____

Do you take any medications / drugs regularly?

NO YES Explain: _____

Have you taken any medications / drugs today?

NO YES Explain: _____

Do you smoke? NO YES How many cigarettes per day? _____ For how many years? _____

Do you consume alcohol? NO YES How many drinks per week? _____

Do you use any recreational drugs such as cocaine, heroin, methamphetamine, etc.?

NO YES Explain: _____

Please CIRCLE if you have ever, in the past or present, had any of the following:

Anemia / Heart Murmur / Asthma / Hay Fever / Bladder Infection / Kidney Infection

High Blood Pressure / Bleeding Problems / Hospitalization / Blood Transfusion /

Rheumatic Fever / Blood Clots / Phlebitis / Sickle Cell Disease / Cancer / Shortness of Breath /

Chest Pain / Stomach Pain / Ulcers / Diabetes / Swollen Feet or Ankles / Epilepsy / Seizures /

Frequent Headaches / Anemia

Chlamydia / Pelvic Inflammatory Disease (PID) / Gonorrhea / Genital Warts / Herpes / Syphilis /

Gall Bladder or Appendix Surgery / Depression / Anxiety

Infectious disease: HIV / Hepatitis C / Hepatitis B

GYNECOLOGICAL HEALTH HISTORY

Are your periods regular? YES NO Days of Flow: _____ First Day of Last Menstrual Period: _____

Normal? YES NO Explain: _____

Have you ever had an internal pelvic examination? YES NO

Last exam / pap smear: _____ Findings: _____

Have you ever had an abnormal pap smear? NO YES When: _____ Treatment: _____

PREGNANCY HISTORY

Number of previous pregnancies: _____

History of twin / multiple pregnancies: NO YES

Number of live births: _____

Month/Years: _____

C-Sections? _____

Complications: _____

Number of stillbirths: _____ Month/Years: _____

C-Sections? _____ Number of miscarriages: _____ Month/Years: _____

D&Cs ? _____ Number of abortions: _____

Number of ectopic pregnancies: _____ Month/Years: _____ Rupture? _____

Are you currently breastfeeding? Yes No

CONTRACEPTIVE HISTORY

Were you using contraception when you became pregnant this time?

NO YES Explain: _____

Have you ever used any of the following birth control methods?

_____ Birth Control Pills When: _____ Brand: _____

Side Effects? _____

_____ Depo Provera / Norplant When: _____

Side Effects? _____

Condoms _____ Foam/Barriers _____ Diaphragm _____ IUD _____

Other: _____

What method of contraception do you plan to use in the future? _____

I certify that the information I have provided is true, correct, and complete.

Signature

Date