Lake Region Family Planning
Health History

Name: _____

Date: _____

Reason for visit today→	**Explain:** (Example: Testing, Treatment, Contraception, Annual Exam, Other health concern)

YES	**NO**		Do you have allergies to food, medication, environment, or latex? List:
YES	**NO**		Are you feeling ill today? Covid symptom? Explain:
YES	**NO**		Do you have a family doctor/primary care physician? Name & Clinic:
YES	**NO**		Are you taking any over the counter medication, vitamins, or health supplements: (Non-Prescription)
YES	**NO**		Have you had recent surgery or hospitalization? Planning a procedure? Explain:
YES	**NO**		Have you had Covid? If yes, what month and year? _____
YES	**NO**		Are your immunizations up to date? Unsure?
YES	**NO**		Are you adopted and unaware of your family health history?

Health History Review of Systems	**NO (√)**	**Current Problem (√)**	**Past Problem (√)**	**Prescription Medication Name & Dose**	**My Family History** List family member with the health issue:
					Example: Parent, Sibling, Grandparent, child, aunt
Depression					
Anxiety					
PTSD					
Other mood issue:					
Headache with aura					
Headache without aura					
Double Vision/Flashy lights					
Numbness/weakness					
Speech Problems					
Other neuro issue:					
Hearing Problems					
Vision Problems:					
Cancer: (List)					

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Health History Review of Systems	**NO (√)**	**Current Problem (√)**	**Past Problem (√)**	**Prescription Medication Name & Dose**	**My Family History** List family member with the health issue:
Heart murmur					
High cholesterol					
Heart attack					
Stroke					
CHF					
A-fib/V-fib					
Cardiomyopathy					
Other cardiac issue:					
Anemia					
Excessive bleeding					
Clotting disorder					
Other bleeding issue:					
Asthma					
COPD					
TB/Exposure to TB					
Sleep apnea					
Other respiratory issue:					
Stomach-heartburn					
Constipation-Diarrhea					
Liver problems					
Diabetes Type 1/Type 2					
Osteoporosis					
Arthritis					
Autoimmune Disorder					
Thyroid Disorder					
Genetic Disorder					
Lymphatic Disorder					
Bladder/kidney Condition					
Frequent UTI					
Acne					
Change in Moles					
Eczema					
Gender Reassignment					XXXXXXXXXXXXXXXXXXXXX

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Health History

Name: _____

Date: _____

Basic Information

My gender at birth: Male - Female

My sexual Orientation: ***Decline to answer*** – Straight – Gay – Bisexual – other - unknown

My gender Identity: ***Decline to answer*** – male – female – transgender Male – transgender female – Gender-queer

I am sexually attracted to: ***Decline to answer*** – males- females – both – neither

CONTRACEPTIVE HISTORY

Method I am using now _____ How long? _____ Do You want to change? Yes/No

Methods I have used in the past: Nothing Withdrawal Foams Gels Abstinence Condom Patch Pills Vaginal Ring Depo Shot Implant IUD Emergency contraception Tubal Ligation Sterilization

Do you need Emergency contraception today? **Yes/ No** To have on hand: **Yes/No**

Are you interested in learning more about Fertility Based Awareness (Natural Family Planning)? **Yes/No**

Males:

Circle any symptoms you are experiencing:

- Pain with urination
- Bumps/sores
- Itching in the groin
- Odor from the groin
- Rash/skin change
- **No symptoms**
- Abdominal pain
- Discharge
- Scrotum pain
- Scrotum swelling
- Pain during sex
- fever

Females:

Circle any symptoms you are experiencing:

- Pain with urination
- Bumps/sores
- Itching in the vulva
- Odor from the vulva
- Rash/skin change
- **No symptoms**
- Burning with urination
- Pain with Sex
- Bleeding during/after sex
- Discharge
- Fever

MALE Reproductive

Yes/No	Have you had a vasectomy?
Yes/No	Have you ever fathered a child?

FEMALE HEALTH HISTORY

The age when you had for very first period: _____yrs.
Date of the first day of your last period: _____(approx.)
Date of most recent pap: _____ Results: Normal/Abnormal/NA
Abnormal pap procedures: colposcopy – cryotherapy – LEEP – nothing- NA

I want to apply for the ***Women's Way*** Program **Yes/No**

FEMALE Reproductive

Total # pregnancies	
Number of live births	
# of tubal pregnancies	
# of miscarriages	
# of abortions	
Date of last delivery:	
Complications? Problems?	
Are you breastfeeding: Yes/No	

Menstrual History (Check all that apply)

□ Skipped periods	□ No periods	□ Emotional Change
□ Spotting between	□ Bloating	□ Skin changes/acne
□ Unpredictable periods	□ Cramping	Heavy Bleeding

Breast Self-Exam Frequency: □ Monthly □ Weekly □ Never

GYN History (Check all that apply)

Uterine fibroids	Polycystic ovarian syndrome
Endometriosis	Pain with intercourse
Difficulty conceiving	Other_____