INITIAL HISTORY – FEMALE

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH – FAMILY PLANNING PROGRAM
SFN 59155 (5-2010)

Do you have a family doctor? ☐ No ☐ Yes-Name of Doctor:	History Date

The health history is an important part of your health care. If you have questions, please ask.

Yes	No	Does anyone in your family have a history of: **(if yes, list who)**	STAFF COMMENTS
		1. Diabetes, sugar in blood or urine?	
		2. High blood pressure?	
		3. High blood cholesterol?	
		4. Stroke?	
		5. Heart attack, heart disease?	
		6. Cancer? What type?	
		7. Birth defects? Genetic disorders? What type?	

Do **YOU** have or have ever had any of the following:

		8. Allergies (food, medication, or latex)?	
		9. Anemia (iron-poor blood)?	
		10. Diabetes?	
		11. Liver or gallbladder disease?	
		12. Urinary tract (bladder) or kidney infection?	
		13. Headaches/migraines (diagnosed)?	
		14. Seizures, epilepsy, blackout, fainting?	
		15. Numbness of face, arms, hands, legs?	
		16. High blood pressure?	
		17. Stroke or blood clots in the legs, lungs, head?	
		18. Asthma? Note medication used:	
		19. Bad chest pain, heart problems, unusual shortness of breath?	
		20. Lumps in the breast?	
		21. Do you check your breasts for lumps?	
		22. Cancer? Where and when?	
		23. Thyroid problems?	
		24. Depression or other mental health history?	
		25. An operation or been hospitalized? When and why? Had a blood transfusion?	
		26. Are you taking any prescription or OTC medications? Herbal, diet supplementals?	
		27. Do you take vitamins/minerals? How often?	
		28. Do you drink caffeine (pop/coffee/tea)? How many cans/cups per day?	
		29. Do you drink alcohol? How often?	
		30. Do you use tobacco—smoke or chew (circle)? If yes, number of cans/cigarettes per day? _____ How long have you been using tobacco? Months: Years: If yes, are you ready to quit or cut back on tobacco? ☐ Yes ☐ No Are you exposed to second-hand smoke? ☐ Yes ☐ No	Advised to quit? ☐ Yes ☐ No Referred? ☐ Yes ☐ No
		31. Do you use street drugs (marijuana, cocaine, crank, methamphetamine, other)? How often?	
		32. Do you have any concerns about your eating? Do you not eat for long periods of time? Do you ever make yourself throw up after eating?	

Name	Date of Birth	Client Number

CONTRACEPTIVE HISTORY

	STAFF COMMENTS
33. What methods of birth control have you used in the past? ☐ Pills ☐ Diaphragm ☐ None ☐ Vaginal Ring ☐ Implant ☐ Condoms ☐ Cervical Cap ☐ Sponge ☐ Fertility awareness ☐ Sterilization ☐ Spermicide (foam) ☐ IUD ☐ Pulling out ☐ Depo Provera ☐ Other	
34. What method are you using now?	
35. What method would you like to use?	
36. Did you have problems with any of the methods? ☐ Yes ☐ No	
37. Did you ever get pregnant while using a birth control method? ☐ Yes ☐ No	

Yes	No	MENSTRUAL/GYNECOLOGICAL HISTORY	
		38. How old were you when your first period started?	
		39. How many days does your period last?	
		40. How often do you get your period?	
		41. Is your period ☐ Light ☐ Average ☐ Heavy	
		42. Do you have pain/cramps with your periods?	
		43. Do you bleed between periods?	
		44. Was your last period normal?	
		45. What was the first day of your last period?	
		46. Are you having sex? ☐ men ☐ women ☐ vaginal ☐ anal ☐ oral If yes, how often do you use condoms? ☐ sometimes ☐ always ☐ never	
		47. How old were you when you first had sex?	
		48. How many sexual partners have you had in the last 60 days? _____ Lifetime? Length of current relationship?	
		49. Have any of your past/present partners had a history of: ☐ injectable drug use ☐ multiple partners ☐ bisexuality ☐ sexually transmitted infections and/or HIV ☐ N/A	
		50. When was the last time you had sexual intercourse?	
		51. Do you have pain or bleeding with sex?	
		52. Do you have difficulty with sex?	
		53. Do you experience pelvic pain?	
		54. Do you have vaginal infections?	
		55. Have you ever been treated for a sexually transmitted infection?	
		56. Have you every had HPV/genital warts?	
		57. Do you have any discharge, rashes, sores, bumps, itching, odor, or burning?	
		58. When was your last pap?	
		59. Have you ever had an abnormal pap? When?	
		60. Have you ever been pregnant?	G P SAB AB
		61. Do you think you might be pregnant now?	
		62. Do you desire a pregnancy in your future?	
		63. How are you at protecting yourself against HIV?	

FOR STAFF USE ONLY

DES exposure Date of expos:	Method & program consent	
Required adolescent counseling (Parental involvement and avoidance of sexual coercion)	ECP:	
Immunizations: Rubella / Hep B / Td or Tdap / HPV	Victim Assessment:	Risk Assessment:
Release of info.		
Initial info. packet given per protocol:	Method ed. per policy:	
Review of annual prescription:	Nutrition:	
Abstinence, Being Faithful, Condoms:	Pre & post interview done per policy: ☐ No ☐ Yes	

Staff Signature:	Date:	
Name:	Date of Birth	Client Number