Planned Parenthood of Delaware

Medical and Surgical History

PLEASE FILL OUT THIS FORM COMPLETELY, IF YOU HAVE QUESTIONS ASK STAFF

Printed Name: _____

Date of Last Menstrual Period? _____ Was this period normal? ❑Yes ❑No*

Do you have any ***ALLERGIES***? ❑ NONE ❑ Latex please list:_____
Are you taking any MEDICATIONS (include over the counter meds, herbal meds and vitamins) and what are they for? Please List:_____

Have you ever had ***ANESTHESIA*** before? ❑Yes ❑No If **Yes**, ❑Local ❑General Any Problems? ❑Yes* ❑No

Yes	No		Yes	No	
❑ *	❑	Do you smoke cigarettes? # day_____	❑*	❑	Alcohol/Drug Use **If yes, type**_____ **Amount/Day** _____

Do You Have:

YES*	No	
❑	❑	Asthma or lung disease
❑	❑	Heart Disease
❑	❑	High Blood Pressure
❑	❑	Blood Clots in Lungs or Legs
❑	❑	Bleeding Disorders
❑	❑	Liver Disease (ex. Cirrhosis, Hepatitis)
❑	❑	Adrenal Failure
❑	❑	Stroke
❑	❑	Seizures/Convulsions
❑	❑	Overactive Thyroid
❑	❑	Diabetes
❑	❑	HIV
❑	❑	Cancer Type_____
❑	❑	Migraines with Aura (**Complete FORM 1100**)
❑	❑	Recent corticosteroid use
❑	❑	Other Chronic Illness _____
❑	❑	Have you had any surgeries on your uterus?
❑	❑	Are you breast feeding?
❑	❑	Have you had breast lumps?
❑	❑	Have you had a sexually transmitted disease
❑	❑	Have you had Pelvic Inflammatory Disease (PID)?

Pregnancy and GYN History:

____ Total number of pregnancies (include this one)
____ Number of live births #_____ vaginal #____ C-section
____ Number of miscarriages, Dates_____
____ Number of abortions, Dates_____
____ Number of ectopic (tubal) pregnancies, Dates_____
____ Number of living children

What method of birth control were you using when you became pregnant? _____
What method of birth control would you like to use?
_____

❑ Yes	❑ No	❑ Decline	My partner refuses to use condoms or has messed with my birth control to get me pregnant.
❑ Yes	❑ No	❑ Decline	My partner makes me have sex when I don't want to.
❑ Yes	❑ No	❑ Decline	My partner tells me who I can and can not talk to.
❑ Yes	❑ No	❑ Decline	My partner has made me afraid or has physically hurt me.
❑ Yes	❑ No	❑ Decline	I am afraid my partner would hurt me if I told him I had an STD and he needed to be treated too.

Client Signature: _____ Date:_____

HCA INITIALS:_____ ❑ Reviewed for Completion ❑ *Asterisk* Answers Reviewed with RN/MD

Nurse Signature:_____ Date:_____

Physician Signature:_____ Date:_____