Summit Family Planning
Medical History

Patient Name ______________________ Age __________ Date __________

How many times have you been pregnant, including this time? ________

# of live births ________ # of miscarriages ________ # of abortions ________ # of c-sections ________

Have you ever had an ectopic or tubal pregnancy? ☐ Yes ☐ No

Have you ever had complications after childbirth, abortion, or miscarriage, including excessive bleeding?

☐ Yes ☐ No explain ______________________

When did your last menstrual period start? ________ Was it a normal period? ☐ Yes ☐ No

Have you had any bleeding since your last period? ☐ Yes ☐ No

What birth control methods have you tried? ______________________

Please list any operations that you have had including c-sections, D&C's, and procedures on your cervix:

____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list the medications and type of reaction below:

____

Are you currently on any medications? ☐ Yes ☐ No If yes, please list them below:

____

Do you use any recreational drugs such as cocaine, heroin, methamphetamine, etc.? ☐ Yes ☐ No

If yes, which drug(s)? ______________ When did you last use? ______________

Do you smoke? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No

Please check if you have, or have had any of the following?

☐ Reaction to iodine
☐ Reaction to novacaine or other anesthetics
☐ Anemia
☐ Asthma
☐ Bleeding tendencies
☐ Blood transfusions
☐ Blood clots in your legs or lungs
☐ Breast lumps or tumors
☐ Diabetes
☐ Heart disease
☐ Heart murmur
☐ Hepatitis
☐ High blood pressure
☐ HIV/AIDS
☐ Kidney disease
☐ Migraine headaches
☐ Mitral valve prolapse
☐ Psychiatric illness
☐ Seizures or epilepsy
☐ Pelvic inflammatory disease (PID)
☐ Chlamydia
☐ Gonorrhea
☐ Genital warts
☐ Herpes
☐ Syphilis
☐ Other ______________

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

Signature ______________________ Date __________