

FAMILY PLANNING VISIT (Patient Questionnaire)



★ HEALTH DEPARTMENT ★

Have you had any of the following?

	Yes	No		Yes	No
Chest pain/ shortness of breath			Breast Lump or Discharge		
Asthma			Liver disease (hepatitis/jaundice)		
Breathing problems			Kidney / Bladder problems		
Depression			Gallbladder Disease		
Blood clots / Clotting disorders			Unusual Vaginal Bleeding		
Seizures / Epilepsy			Abnormal Vaginal Discharge		
Severe or Frequent Headaches			Sexually Transmitted Infection		
Stomach / Bowel Problems			Pelvic infection		

Have you or a family member had any of the following: (Include parents, sisters, brothers, only.)

	Yes	No		Yes	No
High Blood Pressure			Diabetes		
High Cholesterol			Thyroid Problems		
Heart Problems			Breast Cancer		
Stroke			Other Cancer		

Any other health problems? _____

Have you had any surgeries? Yes No _____

Highest completed level of education? _____

Reproductive History

Number of days from first day of period to the first day of the next? _____ Number of days of flow? _____

Any concerns about periods? Yes No

Are you breast feeding? Yes No

How old were you when you first had sex? _____ Are your partners: Male? Female? Both?

What body parts have you used for sex in the past 10 years? Vagina? Mouth? Anus?

How many partners have you had in the last year? _____

Have any of your partners been know to have a sexually transmitted infection? Yes No

Does your partner have abnormal discharge, a wart, or a sore? Yes No

Have any of your partners had HIV or hepatitis? Yes No

Do you use condoms? Yes No

Do you have pain with sex? Yes No

Have you ever felt forced to have sex? Yes No

Have you ever had an HIV test? If yes, results? _____

Do you want a birth control method today? If yes, which method? _____

Are you currently using a birth control method? If yes, which method? _____

What birth control methods have you used in the past? _____

Have you had problems with any method? If so, what? _____

Do you have any other questions or concerns today? Yes No

If so, what? _____

I consent to the examination and treatment (if necessary) by the Polk County Health Department. I understand all information is confidential and can only be released with my consent. I acknowledge receipt of notice of health information and privacy practices.

Signature _____ Date _____