

PREGNANCY HEALTH HISTORY

This medical record is *confidential* and will not be released to anyone except as may be required by law.

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Client Name: _____
Client No. _____
DATE: ____/____/____

Name _____ Date of Birth ____/____/____ Age _____
Last First MI mm / dd / yyyy

Please call me (preferred name) _____ Preferred gender: He _____ She _____ Other: _____
Have you or your partner recently traveled to a region with known Zika or Ebola transmission? ___ Yes ___ No If yes, Where: _____

Are you allergic to:

- Penicillin Iodine Zithromax Doxycycline Sulfa Rocephin Metal Tetracycline
- Amoxicillin Latex Local anesthetic No Allergies other(s): _____

List medications, vitamins, over-the-counter drugs, and/or herbs you take:

REASON FOR YOUR VISIT - PREGNANCY TESTING: Please answer the following questions:

Are you planning a pregnancy at this time? ___ Yes ___ No
If you are pregnant, will you feel? ___ Happy ___ Not sure ___ Sad ___ Worried ___ Other: _____
If you are pregnant, will you proceed with the pregnancy? ___ Yes ___ No ___ Uncertain
Check if you will want information on or assistance with: ___ Financial assistance ___ Nutrition (WIC) ___ Prenatal care
___ Abortion ___ Adoption ___ Infant care ___ Parenting

MENSTRUAL HISTORY

When was the 1st day of your last period: ____/____/____ Was it Normal? ___ Yes ___ No
Have you had sex since your last period? ___ Yes ___ No
Since your last period, have you had any of the following? (check all that apply): breast tenderness fatigue
 increased urination nausea or vomiting pain in your lower abdomen

SEXUAL HISTORY

Age of first intercourse: _____
Have you had a new partner or more than one partner in the last 90 days? ___ Yes ___ No ___ Don't know
Has your partner(s) had a new sex partner or more than one partner in the last 90 days? ___ Yes ___ No ___ Don't know
Have you ever engaged in a sexual activity where you felt you couldn't say no? ___yes ___ no
Check if you have: vaginal sex oral sex anal sex sex with men sex with women sex with both
Check if you have ever had: Chlamydia Gonorrhea HPV/warts Herpes Syphilis HIV
Have you had symptoms or diagnosis of a sexually transmitted infection in the last 90 days? ___ Yes ___ No ___ Don't know
Has your partner had symptoms or diagnosis of a sexually transmitted infection in the last 90 days? ___ Yes ___ No ___ Don't know

PREGNANCY

How many times have you been pregnant? _____
Dates when your pregnancy(ies) ended _____
Have you ever had an ectopic (tubal) pregnancy?
___ Yes ___ No
Are you currently breastfeeding? ___ Yes ___ No

REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? ___ Yes ___ No
How many children do you hope to have? _____
How long do you plan to wait until you (next) become pregnant?

What do you plan to do until you are ready to get pregnant?

What can I do today to help you achieve your plan?

CONTRACEPTION:

Are you currently using a birth control method? ___ No ___ Yes, what kind: _____
When did you last use birth control: _____
If your pregnancy test is negative, do you want a method of birth control today? ___ No ___ Yes, what kind? _____
Does your sexual partner(s) agree with your decision to prevent pregnancy and use birth control at this time? ___ Yes ___ No
Has anyone ever done anything to your birth control - i.e. thrown away your pills, patches, rings or taken his condom off before or during sex?
___ Yes ___ No

SOCIAL HISTORY

Do you smoke? ___ No ___ Yes ___ # per day. Do you want to quit? ___ No ___ Yes
Do you drink alcohol? ___ No ___ Yes Do you use street drugs? ___ No ___ Yes
Does alcohol/drugs cause problems in your life and/or are others concerned? ___ No ___ Yes
Do you feel threatened or afraid of someone in your life? ___ No ___ Yes
Do you have any concerns about: Date rape Forced/unwanted sex Physical abuse Weight
Have you ever received medical care/medications for your mental health? ___ No ___ Yes

PAST MEDICAL HISTORY

Do you have a health care provider if you are pregnant? ___ No ___ Yes
If yes, name & clinic: _____

To the best of my knowledge, the above information is complete and accurate and I request a pregnancy test.

Date: ____/____/____
SIGNATURE OF PATIENT

STAFF COMMENTS: _____

Face to face: _____ Counseling time: _____

Date: ____/____/____

STAFF SIGNATURE