FEMALE TARGET AND INITIAL HISTORY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH – FAMILY PLANNING PROGRAM
SFN 51061 (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 any questions, please ask.

Yes	No		STAFF COMMENTS
		1. Do you have any allergies (food, medications, or latex products)?	
		2. Are you currently taking any type of medication, prescription or over-the-counter? List:	
		3. Are you currently taking any type of herbals, diet pills/supplements or vitamins (St. John's Wort or others)? List:	
		4. Is there a **family** history of (parents, siblings, grandparents, aunts or uncles)? (check all that apply): ☐ Birth defects/genetic disorders ☐ Cancer ☐ Diabetes ☐ High Cholesterol ☐ High blood pressure, heart disease, chest pain or unusual shortness of breath ☐ Liver or gallbladder disease ☐ Seizures, epilepsy, blackouts, or fainting ☐ Stroke or blood clots in legs, lungs or head ☐ Thyroid problems	
		5. Do **you** have a history of (check all that apply): ☐ Birth defects/genetic disorders ☐ Cancer ☐ Diabetes ☐ High Cholesterol ☐ High blood pressure, heart disease, chest pain or unusual shortness of breath ☐ Liver or gallbladder disease ☐ Seizures, epilepsy, blackouts, or fainting ☐ Stroke or blood clots in legs, lungs or head ☐ Thyroid problems	
		6. Have you had or are you planning surgery or hospitalization? When? Why?	
		7. Have you had a blood transfusion or been exposed to any blood products since your last exam?	
		8. Have you been diagnosed with migraines? If so, do you experience any of the following ☐ blurred vision ☐ nausea ☐ dizziness ☐ numbness ☐ aura	
		9. Do you check your breasts for lumps?	
		10. Do you or have you ever had breast cancer?	
		11. Do you use tobacco? ☐ smoke ☐ chew 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
		12. Was your last period normal? What was the first day of your last period?	
		13. Do you bleed between periods?	
		14. Do you skip periods?	
		15. Do you think you might be pregnant now? Date of last sexual intercourse:	
		16. Have you ever become pregnant on birth control?	
		17. Are you breastfeeding?	
		18. When was your last pap?	
		19. Have you ever had an abnormal pap? When?	
		20. How many sexual partners have you had in the last 60 days? _____ Lifetime? Since last exam? Length of current relationship?	

Staff Signature:	Date:

COMPLETE BELOW ONLY IF INSTRUCTED TO DO SO

Contraceptive History

		21. What method/s of birth control have you used in the past? ☐ Cervical Cap ☐ Condoms ☐ Depo Provera ☐ Diaphragm ☐ Fertility awareness ☐ IUD ☐ Norplant/Implant ☐ Vaginal Ring ☐ Patch ☐ Pills ☐ Pulling out ☐ Spermicide (foam) ☐ Sponge ☐ Sterilization ☐ Other ☐ None	
		22. What method are you using now?	
		23. What method would you like to use?	
		24. Did you have problems with any of the methods?	

Name (Print)	Date of Birth	Client Number

Questions 20-54

Yes	No	**Do you have any history of:**	STAFF COMMENTS
		25. Anemia? (low iron in your blood)	
		26. Urinary tract (bladder) or kidney infection?	
		27. Numbness of face, arms, hands, & legs?	
		28. Asthma/Lung disease? List medication:	
		29. Depression or other mental health history?	
		30 Do you drink caffeine (pop/coffee/tea)? How many cans/cups per day?	
		31. Do you use alcohol? If yes, how many drinks? _____ how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other	
		32. Have you ever used street drugs (marijuana, cocaine, crank, methamphetamine, other)? If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other	
		33. Do you have any concerns about your eating?	
		34. Do you not eat for long periods of time?	
		35. Do you ever make yourself throw up after eating?	

Menstrual/Gynecological History

		36. How old were you when your first period started?	
		37. How many days does your period last?	
		38. How often do you get your period?	
		39. What was the first day of your last period?	
		40. Is your period ☐ light ☐ average ☐ heavy	
		41. Do you have pain/cramps with your period?	
		42. Are you having sex? ☐ men ☐ women ☐ vaginal ☐ anal ☐ oral If yes, how often do you use condoms? ☐ sometimes ☐ always ☐ never	
		43. How old were you when you first started having sex?	
		44. 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	
		45. How are you protecting yourself against HIV?	
		46. Do you have pain or bleeding with sex?	
		47. Do you have difficulty with sex?	
		48. Do you experience pelvic pain?	
		49. Do you have vaginal infections?	
		50. Have you ever been treated for a sexually transmitted infection?	
		51. Have you ever had HPV/genital warts?	
		52. Have you noticed: ☐ burning ☐ discharge ☐ itching ☐ odor ☐ rashes ☐ sores ☐ bumps	
		53. Have you ever been pregnant?	☐ G ☐ P ☐ SAB ☐ AB
		54. Do you desire a pregnancy in the future?	

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.	Method ed. per policy:	
Initial info. packet given per protocol:	Nutrition:	
Review of annual prescription:	Deferred exam:	
Abstinence, Being Faithful, Condoms:	Pre & post interview done per policy: ☐ No ☐ Yes	

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