TUSCOLA COUNTY
HEALTH DEPARTMENT

Phone: 989-673-8114 | 1309 Cleaver Road, Suite B, Caro, MI 48723-9135 | Fax: 989-673-7490
www.tchd.us

Date________________________

INITIAL FEMALE PATIENT HISTORY MEDICAL RECORD

ID#______________

Name___________________________________ Birth Date____________________ Age______________
Last First Middle

Maiden Name:____

Marital Status: ❒ Never Married ❒ Married ❒ Divorced ❒ Widowed ❒ Separated ❒ Choose not to respond

Race (***Select one or more***): ❒ White ❒ Black ❒ American Indian or Alaskan Native
❒ Native Hawaiian or Pacific Islander ❒ Asian ❒ Other ❒ Unknown

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Unknown

Address______________________________________ City_____________ State_______ Zip_________

County______________________ Phone #____

How may we contact you? ❒ Phone ❒ Letter

May we leave a message by phone? ❒ Yes ❒ No

If needed, provide another form of contact____

If contacted by letter, can the envelope have the Health Department return address on it? ❒ Yes ❒ No

If you are under 18 years old, do your parents know you are here?__________________________

In case of emergency, who should we contact?____

Phone #_________________ Relationship____

What is the last grade of school you completed_______________ Grade in school now_________________

Do you work? ❒ Yes ❒ No Full-time ❒ Part-time ❒ Where______________________________

Family Doctor:_____________________________ Date of last visit:_____________________________

Have you ever been at this or any other clinic for Family Planning Services? ❒ Yes ❒ No

If yes, where:____ Date of visit:______________________

Are you enrolled in any other Health Department programs at this time or in the past? ❒ Yes ❒ No

If yes, what program(s) ❒ WIC ❒ MIHP ❒ Medicaid Screening (EPSDT) ❒ Other

How did you hear about our program?____

ALL INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR WRITTEN CONSENT, UNLESS REQUIRED BY LAW.

✷ PLEASE GIVE YOUR CORRECT ADDRESS ✷

**ALL CLIENTS UNDER THE AGE OF 18 ARE ENCOURAGED
TO TALK WITH PARENTS ABOUT CONTRACEPTION**

PERSONAL/SOCIAL HISTORY

	YES	NO	?	STAFF NOTES ONLY
Allergies (food, medications, latex)				
Do you have 3 servings of dairy products or take a calcium supplement daily?				
Do you use tobacco? Type________________ How much________________				
Do you use illegal drugs?				
Do you use alcohol? How much/how often______________________________				

MENSTRUAL/GYNECOLOGICAL HISTORY

First day of your last period ______/______/______	Do you have a period every month? ☐ Yes ☐ No
Periods usually last how many days?	Age your first period began:
Do you use ☐ Pads ☐ Tampons ☐ Both	Date of your last pap smear/pelvic exam:
Have you ever had sexual intercourse? ☐ Yes ☐ No	Monthly Breast Self Exam ☐ Yes ☐ No
How many partners have you had in the past year?	Age of first sexual activity?

Have ever been sexually or physically mistreated by a family member or someone else? ☐ Yes ☐ No

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
Unusual vaginal discharge/itching/odor/burning				
Infections in uterus/tubes/ovaries				
Chlamydia, gonorrhea, herpes, syphilis, HPV, etc.				
Pain or bleeding with intercourse				
Missed periods				
Severe menstrual cramps				
Abnormal pap smears				

PREGNANCY HISTORY

Total number of pregnancies _______, still births _______, miscarriages _______, abortions _______, ectopic (tubal)______

Number of children born alive:	Are you planning to have more children? ☐ Yes ☐ No
Do you think you might be pregnant? ☐ Yes ☐ No	Have you tried to become pregnant for more than 12 months without success? ☐ Yes ☐ No

CONTRACEPTIVE HISTORY

	YES	NO
Consistent use of condoms?		

Type of birth control now using

Any problems with it?	How long have you used it?

PARTNER HISTORY

Please check if your partner(s) has a history of any of these activities	YES	NO
Injectable drug use?		
Multiple partners?		
Bisexuality?		
History of STI's?		
History of HIV?		
Homosexuality		

FAMILY HISTORY

HAVE YOUR GRANDPARENTS, PARENTS, BROTHERS, OR SISTERS EVER HAD:	YES	NO	Relationship	STAFF NOTES ONLY
Early coronary artery disease (before age 50)				
High Blood Pressure				
Stroke				
Hyperlipidemia (elevated cholesterol)				
Diabetes				
Breast, ovarian, cervical, colon cancer				
Osteoporosis				
If you were born between 1940-70, did your mother take DES (a hormone to prevent miscarriage)				
Genetic problems				

PAST MEDICAL HISTORY

DO YOU HAVE ANY OFTHE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
Are you being treated for a chronic illness, such as high blood pressure, diabetes, cardiac disease, obesity, kidney or respiratory problems? If so, please list:				
Are you taking any over the counter or prescription medications? If so, please list:				
Have you had any surgeries? If so, please list:				
Have you ever been hospitalized? If so, for what and when:				
Have you had a blood transfusion before 1984?				

REVIEW OF SYSTEMS

DO YOU HAVE ANY OFTHE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
GENERAL HEALTH: (fatigue, weight gain/loss, fevers, recent illnesses)				
EYES: (visual problems, blurring)				
EARS/NOSE/THROAT: (hearing, sinus, oral lesions, difficulty swallowing)				
RESPIRATORY: (shortness of breath, cough, asthma, bronchitis, pneumonia, or bloody sputum)				
CARDIOVASCULAR: (high blood pressure, heart disease, murmurs, chest pains, elevated cholesterol)				

DO YOU HAVE ANY OFTHE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
BLOOD DISORDERS: (anemia, blood clots, bleeding tendency, Sickle Cell Anemia, Factor V)				
GASTROINTESTINAL: (nausea/vomiting, ulcer, diarrhea/constipation, abdominal pain, hepatitis, mono, jaundice)				
URINARY: (urinary tract infection, kidney disease)				
MUSCULOSKELETAL: (arthritis, injuries, osteoporosis)				
ENDOCRINE: (thyroid disease, diabetes, abnormal hair growth, appetite changes)				
SKIN/BREAST: (rash, change in mole, skin lesion, nipple retracting/discharge, breast pain, breast mass/lump/thickness)				
NEUROLOGICAL: (seizure disorder, stroke, severe pain/numbness in arms or legs, headaches (migraine in nature)) If you have headaches: *with nausea and/or vomiting? *with unusual sensitivity/intolerance to sound or light? *see flashing lights and wavy lines with or without headache?				
PSYCHIATRIC: (depressed/moody, anxiety, suicidal thoughts, plan or attempts)				
IMMUNIZATIONS: Up to date with: Measles/Mumps/Rubella Tetanus/Pertussis/Diphtheria Hepatitis B Series Flu HPV infection/vaccine discussed				If not up to date, referred to Immunization Program ☐ Yes ☐ No
OTHER PROBLEMS:				

ARE THERE ANY SPECIAL CONCERNS YOU HAVE TODAY? ______________________________

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To the best of my knowledge, the above information is complete and accurate and has been reviewed by the Family Planning staff.

______________________________ ______________________________

Client Signature Date

______________________________ ______________________________

Reviewed By Date