Midland County Department of Public Health
Family Planning Clinic

Date_____Legal Name: «PName» DOB: «PDOB»

Maiden Name:_____Preferred Name:_____

Please circle:

Birth Sex: Female Male

Identifies as: Female F-to-M Transgender Male M-to-F Transgender Other

Preferred Pronoun: She/Her He/Him They/Them/Theirs

Sexual Orientation: Asexual Bisexual Gay Heterosexual Lesbian Other

PRIMARY CARE PHYSICIAN_____

Please list any changes since your last visit:

New allergies _____

New surgeries _____

New medical problems _____

New family history _____

Current Medications (name, dosage, frequency):

_____

_____

_____

MENSTRUAL HISTORY

First date of Last Menstrual Period_____
Are you in a sexual relationship now_____ When was the last time you had sex_____
Do you have sex with Men_____Women_____Both Men and Women_____
Have you had a new partner in the past 12 months_____
How many lifetime partners_____ How many partners have you had in the past 12 months_____
Have any of your partners had a history of:
Bisexuality_____ Injectable drug use_____ multiple partners_____ Risk for STIs or HIV_____
Have you possibly been exposed to a sexually transmitted disease? (Y)_____ (N)_____
Do you have pain, burning or other problems when you urinate? (Y)____ (N)_____
How do you protect yourself from HIV/AIDS? _____

CONTRACEPTION HISTORY

Have you had vaginal sex without using a condom or other birth control method since your last menstrual period? ____
Have you had a method failure since your last menstrual period? _____
Have you had unprotected sex in the past 72 hours?_____
Are you regulary using a birth control method?_____
If yes what methods do you use? (Please circle all that apply)

Abstinence	Condoms	IUD	Sponge	Diaphragm
Foam/Jelly/Inserts	Depo Provera	Implanon	Contraceptive Pill	Contraceptive Ring
Contraceptive Patch	Natural	Withdrawal	Sterilization	

Do you want to continue your current method of birth control? (Y)____(N)____
If not, what method do you want to use instead?_____

PREGNANCY HISTORY

Number of living children_____
Do you think you may be pregnant now? (Y)____(N)____ Do you want any (more) children? (Y)____(N)____
Have you been trying to get pregnant? _____ If so, how long have you been trying?_____
How often do you and your partner have sex?_____

(***Please Circle yes or no for all the following questions***)

Have you been physically or emotionally abused by your partner or someone else who is important to you?	YES	NO
Have you been hit, slapped, shoved, punched, kicked or in any way physically hurt?	YES	NO
Has anyone forced you to have sex	YES	NO
Are you afraid of your partner	YES	NO
Are you afraid of anyone in your life?	YES	NO
Were you forced to come here for birth control today?	YES	NO
Do you feel threatened or unsafe right now	YES	NO

Have you or your partner traveled anywhere in the last 8 months? If so, when and where? _____
Do you or your partner plan to travel in the near future?_____

SOCIAL/EMOTIONAL HISTORY

Alcohol	Never_____	Occasional_____	Moderate_____	Daily_____
Smoking/Vaping	Never_____	Occasional_____	Moderate_____	Daily_____
Marijuana/Illicit Drugs	Never_____	Occasional_____	Moderate_____	Daily_____
Anxiety/Depression	Never_____	Occasional_____	Moderate_____	Daily_____

Have you ever been in jail, prison, or juvenile detention? (Y)____(N)____
Have you received a tattoo or piercing in an unlicensed setting? (Y)____(N)____

Signed_____

Provider Sign/Reviewed_____