



**PPWP Initial History Form – Comprehensive**  
I-B-3f/July 2007

PT LABEL

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

E. PREGNANCY HISTORY <span style="float: right;"><input type="checkbox"/> never pregnant</span>								
DELIVERED					ABORTION / MISCARRIAGE			
Mo.	Yr.	Vag.	C-Sec.	Birth Weight	Year	Weeks	Spont.	Induced

**F. CONTRACEPTIVE HISTORY**

Current birth control method? \_\_\_\_\_ How long used? \_\_\_\_\_

Any problems with this method?  Yes  No  
If yes, what? \_\_\_\_\_

What method do you want to use now? \_\_\_\_\_

Total number of children desired? \_\_\_\_\_

Are you planning a pregnancy in the NEXT year?  Yes  No  
If not, what would you do if you become pregnant within the NEXT year? \_\_\_\_\_

**WHICH OF THE FOLLOWING METHODS HAVE YOU USED IN THE PAST?**

METHOD	COMMENT/PROBLEM
<input type="checkbox"/> Abstinence?	
<input type="checkbox"/> Tubal? <input type="checkbox"/> Vasectomy? <input type="checkbox"/> Hysterectomy?	
<input type="checkbox"/> Birth Control Pill?	
<input type="checkbox"/> The Patch?	
<input type="checkbox"/> The Ring?	
Implant: <input type="checkbox"/> Norplant? <input type="checkbox"/> Implanon?	
<input type="checkbox"/> Depo-Provera (The Shot)?	
<input type="checkbox"/> IUD?	
<input type="checkbox"/> Condoms?	
<input type="checkbox"/> Diaphragm? <input type="checkbox"/> FemCap?	
<input type="checkbox"/> Lea's Shield?	
<input type="checkbox"/> Sponge? <input type="checkbox"/> Spermicide?	
<input type="checkbox"/> Rhythm?	
<input type="checkbox"/> NFP (Natural Family Planning)?	
<input type="checkbox"/> Withdrawal?	

**G. SOCIAL HISTORY**

Emotional?  Relationship problems?

Death of  Family member?  Friend?

Job loss?  Financial problems?

Problems in  Living arrangements?  School?

Legal problems?  Arrests?  Divorce?

Do you have any parental problems?

Are you physically abused?

Has anyone forced you to have sex?

Are you sexually abused?

Are you afraid of your  Partner?  Family member?

Who helps and supports you with your problems? \_\_\_\_\_

**H. MENSTRUAL HISTORY**

1. Age periods began? \_\_\_\_\_
2. Number of pads / tampons used on heaviest day? \_\_\_\_\_
3. Length of period? \_\_\_\_\_ (days) # of days between periods?
4. Are your periods usually regular?  Yes  No
5. Last period started on \_\_\_\_\_  
It seemed  Normal  Not normal
6. Do you experience, before or with periods,  Cramps?  
 Bloating?  Bowel problems?  Emotional changes?
7. Do you have vaginal bleeding after sex?  Yes  No
8. Do you have vaginal bleeding between menstrual periods?  
 Yes  No

**I. STI / HIV RISKS**

Number of sex partners in your life? MEN \_\_\_\_\_ WOMEN \_\_\_\_\_  
How many sex partners have you had during the past year? \_\_\_\_\_

Does your partner have sex with  men  women  both?  
Do you have (check all that apply)  vaginal  oral  anal sex?

**COMMENTS**

Have you ever used street drugs?  
If yes, when? \_\_\_\_\_

Have you received blood or blood products prior to 1978? \_\_\_\_\_

Were any of your partners:  a street drug user?  
 a Hemophiliac?  infected with HIV / AIDS?  
 MSM (men having sex with men)?

Have you ever shared needles?  
Examples: Injecting drugs, tattooing, piercing?

**STAFF COMMENTS (do not write anything in this space)**

**To the best of my knowledge the information I have provided is correct and complete.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

**History reviewed:**

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_