Memphis Center for Reproductive Health
PATIENT DEMOGRAPHIC

PT# _____
DATE: _____
DOB: _____

Client Name: _____

ALL INFORMATION IS CONFIDENTIAL. PLEASE PRINT IN BLACK INK.

Your address, phone numbers and contact person are used to contact you about lab results or your medical care.

Address: _____
Full Address City County State Zip

Patient Phone Number: (H): _____ (C): _____

MCRH can leave a message at: (circle) Home Cell With a person (name): _____

Email address _____ Can we add you to our mailing list YES☐ NO☐

Primary Care Provider Name: _____ Phone # (____) _____

Occupation: _____ Age: _____ Social Security #: _____

Do you have health insurance? YES NO (Type) _____

Emergency Contact Person: _____ Relationship to you: _____ Phone # (____) _____

Does this person know that you are here for services? YES NO

Who is with you today? _____ Phone #: (____) _____

Have you been a patient at MCRH in the past (circle) YES NO Year of visit: _____
Has your medical history changed since your last visit? YES NO

If yes, please explain: _____

_____

Please circle: Married Single Divorced Widowed Partnered

Circle the highest grade completed:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

Ethnicity: (Please circle any/all that apply)

Asian African American Caucasian Hispanic American Indian Other: _____

How did you hear about us? (Please circle all that apply)

1. I was a previous patient
2. Phonebook
3. Family/Friend
4. MD/Medical Family
5. Abortion Hotline/NAF
6. Internet
7. Newspaper Ad
8. Other: (Specify)

According to Chapter 1200-8-13 "Standards for Ambulatory Surgical Treatment Centers" for the State of TN
Any adult or emancipated minor may execute an advance directive health care
Do you want to execute an advance directive for health care?
____YES ____NO

Signature of patient: _____ Date: _____

(IF YOU ARE HERE FOR AN ABORTION, PLEASE COMPLETE THE BACK OF THIS SHEET)

If you are having an abortion today please answer the following questions

Circle all the words that describe how you feel right now:

Sad Happy Angry Confident Guilty Confused Scared Relieved Numb Ashamed

Resolved Selfish Trapped Irresponsible Peaceful Disappointed Comfortable Grieving

Is anyone pressuring or forcing you to have this abortion? _____Yes _____No

I understand my alternatives to having an abortion. I am firm in my decision to terminate this pregnancy.

(Please Initial) _____ Yes _____ No CDD cost for a PAP Smear is $10.00

_____ _____

Patient Signature Date

DO NOT WRITE BELOW THIS LINE

PAP smear? _____ Yes _____ No

Prescription for Birth Control _____ Yes _____ No

Method _____

OTHER PATIENT CONCERNS_____

_____ _____

Patient Educator Signature Date

Memphis Center for Reproductive Health
MEDICAL HISTORY

PT#_____
DATE:_____
DOB:_____

CLIENT NAME: _____

All information is confidential. Please print in black ink.

Reason for your visit: ☐ Pregnancy Termination ☐ Pap Smear/STI Testing/Birth Control ☐ IUD ☐ Consult

Past Medical History:

ALLERGIES

YES	NO	
☐	☐	LATEX
☐	☐	TETRACYCLINE/DOXYCYCLINE
☐	☐	ASPRIN
☐	☐	NOVACAINE/LIDOCAINE
☐	☐	IODINE/SHELLFISH
☐	☐	Do you have allergies to any other drug? If **YES**, list: _____
☐	☐	Are you taking any medications (including vitamins or herbal medications):

_____
_____
_____

☐ ☐ Are you taking any unprescribed drugs or medications? If **YES**, list:

_____
_____
_____

YES	NO	
☐	☐	Do you smoke? # per day _____ How many years _____
☐	☐	Would you like a referral for smoking cesation
☐	☐	Do you drink alcohol? If yes: How often do you drink more than 2 drinks: Daily Weekly Monthly
☐	☐	Do you or your partner use injection medications or drugs?
☐	☐	Are you experiencing any neglect, violence or abuse?
☐	☐	Do you have any dietary concerns today? If Yes: _____
☐	☐	Do you you exercise regularly? _____ X per week Type of exercise: _____
☐	☐	Do you drink caffeine? _____ cups per day.
☐	☐	Do you need a referral today? FOR:_____

How many times have you been pregnant? _____
How many pregnancies did you conitnue full term (>37-40 weeks)? _____
How many pregnancies were premature? _____
How many abortions have you had? _____
How many miscarriages have you had? _____
How many living children do you have? _____

Year of Pregnancy	Type of Delivery	Weeks Pregnant

Any pregnancy complications?

☐ hypertension ☐ postpartum depression
☐ postpartum hemmorhage ☐ other

treated/how? _____

_____

Menstrual History

When was the first day of your last period? _____

YES	NO	
☐	☐	Was it a normal period? If **NO**, explain:_____
☐	☐	Have you had cramping or bleeding with this pregnancy? If **YES**, explain: _____

How often do your periods occur? Every _____ days
How long do your periods usually last? _____ days
How old were you when your periods began? _____ years old

YES	NO	
☐	☐	breast surgery, lump or other problem
☐	☐	tumor or fibroid in the uterus
☐	☐	abnormalities of the uterus
☐	☐	sores/bumps in genital area
☐	☐	vaginal itching/discharge/odor
☐	☐	pain or bleeding with sex
☐	☐	loss of intrest in sex
☐	☐	Have you had a pelvic exam before?

Date of last pap smear _____
Previous abnormal pap smear _____

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING:

YES	NO		
☐	☐	Pelvic Inflammatory Disease (PID)	____ year
☐	☐	Genital Warts (HPV)	_____ year
☐	☐	Herpes (HSV)	_____ year
☐	☐	Gonorrhea	_____ year
☐	☐	Chlamydia	_____ year
☐	☐	Syphillis	_____ year
☐	☐	HIV / AIDS	_____ year
☐	☐	Partner with infection or symptoms _____	

BIRTH CONTROL

YES	NO	**Have you ever used:**
☐	☐	birth control pills (type: _____)
☐	☐	cervical cap
☐	☐	condoms
☐	☐	Depo Provera shots
☐	☐	diaphragm
☐	☐	IUD (Intra-uterine Device)
☐	☐	Nuvaring (vaginal ring)
☐	☐	Ortho Evra (patch)
☐	☐	natural family planning
☐	☐	Norplant/Implanon
☐	☐	spermicides
☐	☐	sterilization
☐	☐	withdrawal
☐	☐	problems with any method?
		If "yes" explain:_____
		_____
☐	☐	Were you using a method when you became pregnant?
		What method?_____
☐	☐	Postmenopausal
☐	☐	Are you currently taking HRT
		How Long? _____
		What year was your last menses_____

GENERAL MEDICAL HISTORY

Have YOU ever had:

YES	NO	
☐	☐	diabetes (gestational or other)
☐	☐	cancer (type: _____)
☐	☐	thyroid disease
☐	☐	sickle cell trait or disease
☐	☐	heart murmur / mitral valve prolapse
☐	☐	heart attack, heart problem or chest pain
☐	☐	asthma or breathing problems
☐	☐	blurred or double vision
☐	☐	anemia
☐	☐	high blood pressure
☐	☐	numbness in arms or legs
☐	☐	blood clots in arms, legs or lungs
☐	☐	redness, pain or swelling in arms or legs
☐	☐	emotional problems (i.e. depression)
☐	☐	tuberculosis
☐	☐	liver problems or hepatitis
☐	☐	kidney or bladder problem
☐	☐	stomach problems
☐	☐	gall bladder problems
☐	☐	seizure disorder or epilepsy
☐	☐	genetic abnormality
☐	☐	MD diagnosed migraine headaches
☐	☐	frequent or severe headaches
☐	☐	major surgery or car accident (not childbirth):

LIST SURGERY	YEAR
_____	_____
_____	_____
_____	_____

YES	NO	Hospitalizations (not childbirth)
☐	☐	

Reason	YEAR
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Have your ***PARENTS, BROTHERS, OR SISTERS:***

YES	NO	
☐	☐	cancer (type: _____)
☐	☐	diabetes (insulin or diet controlled)
☐	☐	tuberculosis
☐	☐	sickle cell trait or disease
☐	☐	death from a heart attack before age 50
☐	☐	epilepsy
☐	☐	thyroid problems

Form completed by: ☐ Patient ☐ Clinician ☐ Patient Educator ☐ Other

Signature of patient: _____ Date: _____

Clinician Signature: _____ Date: _____

Clinician Signature: _____ Date: _____