

Today's Date: ____ / ____ / ____ Age: _____ Family Doctor: _____ LEP: Interpreter _____

Please or describe all that apply.

What is the main reason for your visit today?		
Are you currently planning a pregnancy? <input type="checkbox"/> yes <input type="checkbox"/> no		
What was the 1 st day of your last menstrual period? _____	Are your periods regular? <input type="checkbox"/> yes <input type="checkbox"/> no	
Are you having any problems or symptoms today that you would like to discuss? <input type="checkbox"/> yes <input type="checkbox"/> no If you answered yes, please briefly explain:		
Are you allergic to any medicines or foods? <input type="checkbox"/> yes <input type="checkbox"/> no If you answered yes, please list what medicines or foods you are allergic to and your reaction to each:		
Current medications (<i>Prescription / Over the counter</i>): <input type="checkbox"/> None <input type="checkbox"/> Multivitamins <input type="checkbox"/> Folic Acid <input type="checkbox"/> Calcium <input type="checkbox"/> Birth Control: If using birth control, has there been a break in your method? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Other:		
Nutrition: check foods you eat every day <input type="checkbox"/> Milk / Dairy <input type="checkbox"/> Meats <input type="checkbox"/> Vegetables <input type="checkbox"/> Fruits <input type="checkbox"/> Breads or Grains	Do you have concerns about your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No	Exercise <input type="checkbox"/> None <input type="checkbox"/> Seldom <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent
Tobacco Use/ Smoke Exposure (cigarettes, cigars, pipe, dip, chew, snuff) <input type="checkbox"/> Never used <input type="checkbox"/> Exposed to smoke <input type="checkbox"/> Past user: type _____ <input type="checkbox"/> Use now: type _____ (# per day _____)	Alcohol or Street Drugs <input type="checkbox"/> None <input type="checkbox"/> Seldom: type _____ <input type="checkbox"/> Occasional: type _____ <input type="checkbox"/> Frequent : type _____	
Mental Health: (<i>in past 90 days</i>) <input type="checkbox"/> No Problem <input type="checkbox"/> Mild/Moderate Depression <input type="checkbox"/> Severe Depression <input type="checkbox"/> Thoughts of harming self / others		
Dental Health <input type="checkbox"/> Brush daily <input type="checkbox"/> Floss daily <input type="checkbox"/> Visit dentist every 6 months		
Abuse / Neglect / Violence: <input type="checkbox"/> No fear of harm <input type="checkbox"/> Pressure to have sex <input type="checkbox"/> Daily needs not met <input type="checkbox"/> Forced sexual contact <input type="checkbox"/> Fear of verbal/physical abuse <input type="checkbox"/> Sex for money or drugs		
Do you use condoms to protect against sexually transmitted diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been treated for a sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply. <input type="checkbox"/> Chlamydia; when? _____ <input type="checkbox"/> Gonorrhea; when? _____ <input type="checkbox"/> Herpes; when? _____ <input type="checkbox"/> Syphilis; when? _____ <input type="checkbox"/> HIV/AIDS; when? _____ <input type="checkbox"/> HPV/Genital Warts; when? _____ <input type="checkbox"/> Other: _____; when? _____		
Patient Signature:	Healthcare Provider Signature:	Date:

THIS PAGE TO BE COMPLETED BY HEALTHCARE PROVIDER

Health Education: topics discussed today					
<input type="checkbox"/> Prenatal Counseling	<input type="checkbox"/> Preconception /Folic Acid	<input type="checkbox"/> Options Counseling	<input type="checkbox"/> STD	<input type="checkbox"/> Family Planning	<input type="checkbox"/> Physical activity
<input type="checkbox"/> Diet/Nutrition	<input type="checkbox"/> ATOD / Cessation / SHS	<input type="checkbox"/> Pelvic/ Pap	<input type="checkbox"/> Safety	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Dental
<input type="checkbox"/> Lead exposure (ACH-25a) <input type="checkbox"/> MINOR Family Planning: Sexual coercion. Abstinence. Benefits of parental involvement.					
Educational Handouts: <input type="checkbox"/> PTEM <input type="checkbox"/> STDEM <input type="checkbox"/> PN Packet				<input type="checkbox"/> Patient verbalizes understanding of education given	
<input type="checkbox"/> Other:					

Positive Pregnancy Test Only					
EDC _____	G	Para	SAB	ETP	OB pt plans to use: _____
		# living children:			
Verbal Lead Risk Assessment: <input type="checkbox"/> neg <input type="checkbox"/> pos : risk factor(s) _____					
Referred for testing: <input type="checkbox"/> yes <input type="checkbox"/> no					
Medications: <input type="checkbox"/> Prenatal Vitamins: Number of bottles given _____					

Negative Pregnancy Test Only	
Medications: <input type="checkbox"/> N/A <input type="checkbox"/> Folic Acid/MVI: Number of bottles given _____	<input type="checkbox"/> ECP
<input type="checkbox"/> Birth Control: _____	

General Appearance: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:	
Testing today:	
<input type="checkbox"/> GC	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> VDRL	<input type="checkbox"/> HIV
<input type="checkbox"/> Urine PT / UCG:	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
<input type="checkbox"/> Other:	
Referrals made:	
<input type="checkbox"/> N/A	<input type="checkbox"/> FP Program
<input type="checkbox"/> PCP	<input type="checkbox"/> MNT
<input type="checkbox"/> Presumptive Eligibility	<input type="checkbox"/> DCBS
<input type="checkbox"/> 1-800-QUIT-NOW	<input type="checkbox"/> WIC
<input type="checkbox"/> Cooper Clayton Classes	<input type="checkbox"/> HANDS
<input type="checkbox"/> Other:	<input type="checkbox"/> KIDS NOW
Healthcare Provider Signature:	Date:
	Recommended RTC: