

Date \_\_\_\_\_

| TO BE COMPLETED BY PATIENT                                                                                                                                                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| What is the main reason for your visit today?                                                                                                                                                                                                                                                          |  |
| Are you having any problems with your birth control method that you would like to discuss? <input type="checkbox"/> yes <input type="checkbox"/> no<br>If you answered yes, please briefly explain:                                                                                                    |  |
| What was the 1st day of your last menstrual period?                                                                                                                                                                                                                                                    |  |
| Are you allergic to any medicines or foods? <input type="checkbox"/> yes <input type="checkbox"/> no<br>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<br><input type="checkbox"/> Birth Control, type: _____ <input type="checkbox"/> Other: _____ |  |
| Since your last visit, have you had any hospitalizations, major injuries, surgeries or other changes to your medical history? <input type="checkbox"/> yes <input type="checkbox"/> no<br>If you answered yes, please briefly explain:                                                                 |  |

|                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tobacco Use/ Smoke Exposure (cigarettes, cigars, pipe, dip, chew, snuff, vaping):</b><br><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 _____) |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |
| <b>Alcohol</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Seldom: type _____<br><input type="checkbox"/> Occasional: type _____<br><input type="checkbox"/> Frequent: type _____                                                                                      | <b>Street Drugs</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Seldom: type _____<br><input type="checkbox"/> Occasional: type _____<br><input type="checkbox"/> Frequent: type _____                                                                                                                                         | <b>Mental Health: (in past 90 days)</b><br><input type="checkbox"/> No Problem<br><input type="checkbox"/> Mild/Moderate Depression<br><input type="checkbox"/> Severe Depression<br><br><input type="checkbox"/> Thoughts of harming self / others | <b>Abuse / Neglect / Violence:</b><br><input type="checkbox"/> No fear of harm <input type="checkbox"/> Pressure to have sex<br><input type="checkbox"/> Daily needs not met <input type="checkbox"/> Forced sexual contact<br><input type="checkbox"/> Fear of verbal/physical abuse<br><input type="checkbox"/> Sex for money or drugs |
| Are you sexually active: <input type="checkbox"/> Yes: date of last sex _____<br><input type="checkbox"/> No (If no, skip the next questions and sign below.)                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                 | Sexually Active with: <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both<br><input type="checkbox"/> Anonymous partners                                                                                  |                                                                                                                                                                                                                                                                                                                                          |
| Do you use condoms to protect against sexually transmitted diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |
| Have you had a new sexual partner within the past 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |
| How many sexual partners have you had in the past 12 months? _____                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |
| Have you had any known exposure to a sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                             | <b>Check symptoms you are having:</b> <input type="checkbox"/> No Complaints<br><input type="checkbox"/> Discharge <input type="checkbox"/> Odor <input type="checkbox"/> Sores <input type="checkbox"/> Pain in genital area <input type="checkbox"/> Rash <input type="checkbox"/> Bumps<br><input type="checkbox"/> Genital itch Other _____ |                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

| TO BE COMPLETED BY HEALTHCARE PROVIDER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ABUSE, NEGLECT, VIOLENCE: ( <i>sexually active minors only</i> ): Age of partner: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                         |
| Interruption in B/C method? <input type="checkbox"/> yes <input type="checkbox"/> no Describe: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                         |
| Any unprotected sex in last 5 days? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date of unprotected sex _____                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                         |
| Any problems with method or ACHES/PAINS? <input type="checkbox"/> yes <input type="checkbox"/> no Describe: _____                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                         |
| <b>Health Education: topics discussed today</b><br><input type="checkbox"/> Counseled on birth control method <input type="checkbox"/> Preconception /Folic Acid<br><input type="checkbox"/> Calcium Supplementation <input type="checkbox"/> Diet / Nutrition<br><input type="checkbox"/> Physical activity <input type="checkbox"/> Mental Health<br><input type="checkbox"/> ATOD / Cessation / SHS <input type="checkbox"/> STD / HIV<br><input type="checkbox"/> MINOR Family Planning: Sexual coercion. Abstinence. Benefits of parental involvement. | <b>Educational Handouts:</b><br><input type="checkbox"/> FPEM <input type="checkbox"/> PTEM<br><input type="checkbox"/> STDEM <input type="checkbox"/> Other: _____<br><br><input type="checkbox"/> Patient voices understanding of education given. <input type="checkbox"/> A&O x3<br><input type="checkbox"/> Appearance WNL                  |                                                                                                                                                                                                                                                                                                                         |
| <b>Testing today:</b> <input type="checkbox"/> N/A<br><input type="checkbox"/> GC<br><input type="checkbox"/> Chlamydia<br><input type="checkbox"/> VDRL<br><input type="checkbox"/> HIV<br><input type="checkbox"/> Urine PT / UCG: <input type="checkbox"/> Pos <input type="checkbox"/> Neg<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                     | <b>Medications/Supplies:</b><br><input type="checkbox"/> Foam issued (#) _____<br><input type="checkbox"/> Condoms issued (#) _____<br><input type="checkbox"/> ECP<br><input type="checkbox"/> Birth Control Method given: _____<br><br><input type="checkbox"/> Foam and Condoms offered, pt declined<br><input type="checkbox"/> Other: _____ | <b>Referrals made:</b> <input type="checkbox"/> N/A<br><input type="checkbox"/> 1-800-QUIT-NOW<br><input type="checkbox"/> Smoking Cessation Program: _____<br><br><input type="checkbox"/> PCP<br><input type="checkbox"/> MNT<br><input type="checkbox"/> FP Medical Revisit<br><input type="checkbox"/> Other: _____ |

Notes: \_\_\_\_\_  
 Healthcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Recommended RTC: \_\_\_\_\_