Family Planning Service Visit

Patient Label

SUBJECTIVE: **TO BE COMPLETED BY THE PATIENT**

Please answer the following questions to the best of your ability so that we can better serve you.

What is the main reason for your visit today?

Are you allergic to any medicines or foods? ❑ yes ❑ no If you answered yes, please list what medicines or foods you are allergic to and your reaction to each: _____

Tobacco Use/ Smoke Exposure (cigarettes, cigars, pipe, dip, chew, snuff): ❑Never used ❑ Exposed to smoke
❑Past user: type _____ ❑Use now: type_____ (# per day _____)

Alcohol: ❑None ❑Seldom: type_____ ❑Occasional: type_____ ❑Frequent: type_____

Street Drugs: ❑None ❑Seldom: type_____ ❑Occasional: type_____
❑Frequent: type_____

Current medications (*Prescription / Over the counter*): ❑ None ❑Multivitamins ❑Calcium
❑Birth Control (Type: _____) ❑ Other:

Have you received the following vaccinations? ❑ HPV # of doses_____ ❑ Hepatitis B ❑ MMR
Other:_____

List any Currently Diagnosed Medical Conditions:

History of: ❑ depression ❑ anxiety ❑ other mental health issue: _____ ❑ none

Abuse / Neglect / Violence: Are you experiencing any of the following? ❑Pressure to have sex ❑Forced sexual contact
❑ Verbal/physical abuse ❑Daily needs not met ❑ None of these

Reproductive Health

First day of last menstrual period:_____/_____/_____	**# of pregnancies**_____ **# of live births** _____
Frequency of periods: _____ **Length of bleeding**: _____ days **Amount of bleeding**: ❑ Light ❑ Medium ❑ Heavy	**When was your last Pap or HPV test?** ____/____/____ Was the result normal? ❑ Yes ❑ No

Have you had any obstetrical or gynecological surgeries or procedures? ❑ yes ❑ no
If you answered yes, please briefly explain:

Reproductive Life Plan:
Do you want more children? □ yes □ no If yes, how many more children do you want to have and when? _____
If no, what are you currently using to prevent pregnancy? _____

Sexually Active with: ❑ Males ❑ Females ❑ Both males and females ❑ Anonymous partners

Number of partners: in past month: _____ in past 2 months: _____ in past 12 months: _____

In the last 60 days,

Have you had oral sex: ❑no ❑yes; when _____ given / received/ both Partners: ❑Male ❑Female ❑Both
Have you had genital sex: ❑no ❑yes; when_____ Partners: ❑Male ❑Female ❑Both
Have you had anal sex: ❑no ❑yes; when _____ given / received/ both Partners: ❑Male ❑Female ❑Both

Have you been treated for any STDs in your past? Check all that apply. ❑Chlamydia ❑Gonorrhea
❑Herpes ❑HIV/AIDS ❑HPV or Genital Warts ❑Syphilis ❑Trichomoniasis ❑Other:

Date of last HIV test: _____ ❑ Never **Date of last Hepatitis C test:** _____

Do you use condoms? ❑ Always ❑ Sometimes ❑ Never

Check symptoms you are having: ❑No complaints ❑discharge ❑odor ❑sores
❑ pain in genital area ❑rash ❑bumps ❑genital itch
❑ burning/pain with urination ❑frequent urination ❑other:

When did your symptoms start? _____

Have you taken any medications or done anything to relieve the symptoms? _____

Patient Signature: Date:

Reviewed by Healthcare Provider Signature: Date:

OBJECTIVE: To be completed by Healthcare Provider

REASON FOR VISIT: Desires contraception *(note: If the patient is also presenting for additional services, an HP-13 or HP-14 must be completed)*

Patient's Partner(s) History: ❑ STD _____ ❑HIV ❑Hepatitis C ❑ IV Drug Use ❑ Multiple partners ❑ None of these

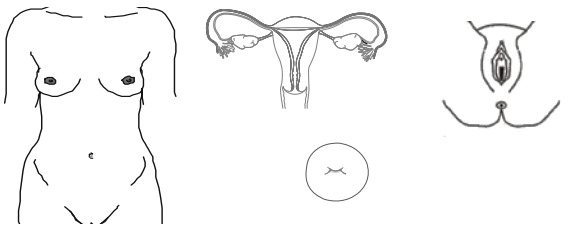
Sexually active minors : Age of partner: _____

Is there a risk of exploitation ❑Yes ❑No If yes, explain _____

Contraception: Current method:_____ Difficulties with method:_____
Desired method, if different from current method_____

Other Cervical Cancer Risk Factors: Age when first had sex _____ DES Exposure? ❑ yes ❑ no
Abnormal vaginal bleeding, explain: _____

Physical Examination		WNL	Abnormal Findings
Respiratory	Respiratory effort		
	Lungs		
Cardiovascular	Heart		
Breast	Nipples		
	Breasts		
Gastrointestinal	Abdomen		
	Anus / Perineum		
Female Genitourinary	Genitalia		
	Vagina		
	Cervix		
	Uterus		
	Adnexa		



Other Observations

ASSESSMENT:

PLAN:

Testing today*:*
❑ GC-CT urine ❑ Hepatitis C
❑ GC-CT swab ❑ HIV Blood
❑ UA ❑ HIV Oral
❑ VDRL ❑Herpes Culture
❑ Pap ❑ Wet Mount
❑ CBE
❑ Urine PT / UCG: ❑Pos ❑Neg
❑ Other:

Medications/Supplies: ❑ N/A
❑ Birth Control Method _____
❑given today ❑Rx given
❑ MV / Folic Acid
Number of bottles_____
❑ Foam Issued (#) _____
❑ Condoms Issued (#) _____
❑ Foam/Condoms offered, patient declined
❑ STD Medication _____
❑ Other:

Recommendations made to client for scheduling of follow-up testing and procedures, based on assessment:
❑ N/A
❑ Vision ❑ Hearing
❑ Pap Smear ❑ Mammogram
❑ Ultrasound ❑ Colorectal Scr.
❑UCG/HCG ❑Ovarian Cancer Scr
❑ Other:

Referrals made: ❑ N/A
❑ PCP, Medical Home
❑ HANDS
❑ Pediatrician
❑ WIC
❑ Specialist:
❑ Radiology
❑ Medicaid
❑ Social Services
❑ 1-800-QUIT-NOW
❑ Freedom from Smoking
❑ Other:

Preventative Health Education *check counseling topics discussed today*

❑ Family planning
❑ STD
❑ HIV
❑ HIV Pretest
❑ Partner Notification
❑ Risk Reduction
❑ Condom use for STD
❑ Condom use for pregnancy prevention
❑ PPT - Options counseling

❑ Reproductive Life Plan
❑ATOD / Cessation
❑ Mental Health
❑ Preconception / Folic Acid
❑ DV/SA/Abuse
❑ Cancer
❑ SBE /Mammogram
❑ Pelvic / Pap

Minor Family Planning Counseling:
❑ Abstinence ❑ Sexual coercion
❑ Benefits of parental involvement in choices

Educational Handouts:
❑ FPEM ❑ PTEM ❑ CSEM
❑ Other:

❑ Patient verbalizes understanding of education given.

Healthcare Provider Signature: Date: Recommended RTC: