

Date: _____

***Some of these questions are personal, but they help us in evaluating your health.**

Reason for today's visit _____		Age: _____
PAST MEDICAL HISTORY		SOCIAL HISTORY ♥
Yes	No	Nicotine, Alcohol, and/or Drug Use
	Are you allergic to <input type="checkbox"/> latex <input type="checkbox"/> medication (please list) _____	Smoke cigarettes, cigars, pipes, or chew tobacco How much per day? _____
	Have you been under a provider's care for any illness or chronic condition? If yes, describe: _____	Drink alcohol (beer, wine, liquor) _____ drinks per week
	Are you taking any medications (drugs, vitamins, over the counter medication, and herbal medication)? ♥ If yes, please list: _____	Do you or your partner use street or IV drugs?
		Do you feel like you should cut down or stop using alcohol/drugs?
		Relationship & Safety
HOSPITALIZATIONS / SURGERIES		Violence and sexual abuse are common in many people's lives. There is help for you if you are being hurt or abused.
Year	Reason	My partner has threatened or frightened me. <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline
		My partner has physically abused me. <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline
FAMILY PLANNING HISTORY		I have been forced to have sex. <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline
Yes	No	GYN HISTORY
	Do you hope to ever have (more) children? If yes, when? <input type="checkbox"/> More than one year <input type="checkbox"/> Less than one year <input type="checkbox"/> unsure	_____ What was the first day of your last normal menstrual period? _____ Age periods started
	Do you or your partner use birth control now? If so, what? _____ How long have you used this method? _____ If no method, why not? <input type="checkbox"/> trying to get pregnant <input type="checkbox"/> partner(s) is same sex <input type="checkbox"/> other _____	Periods came every _____ days and last _____ days Please describe any problems you have had with your periods: _____
	Are you happy with your current birth control method?	Is this your first pelvic (GYN) exam? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you know about Emergency Contraception (EC) & that you can buy it without a prescription if you are ≥ 17 years old?	Yes No Do you have any of the following?
		Breast pain, lump, or discharge
		Sores or bumps on or in genital area
SEXUAL HISTORY		Unusual vaginal discharge
What are you using to protect yourself from sexually transmitted infections? _____		Pain with urination
Yes	No	Unusual vaginal bleeding
	Are you sexually active now? Check all that apply. <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral <input type="checkbox"/> Sex toys Date of last sex? _____	Do you protect yourself from pregnancy? If yes, how? _____ Date of last sex without a birth control method: _____
	Have you or your partner had a new or more than one sexual partner in the past 3 months? # of partners you have had in past 12 months: _____ Partners are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both <input type="checkbox"/> Trans	Previous pregnancies. # pregnancies _____ # children _____
	Have you ever had a sexually transmitted infection? ♥ If so, please check: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Genital Warts <input type="checkbox"/> Cervical HPV <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Herpes <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomoniasis <input type="checkbox"/> Other _____	Previous ectopic (tubal) or molar pregnancy
		Do you think you might be pregnant now?
		Breastfeeding now?
		Genital trauma/surgery. Please explain? _____
		Bleeding or pain during sex
		Do you douche?
		FILL OUT THIS SECTION IF YOU ARE UNDER 18 YEARS OLD
Yes	No	
	Has your partner been treated for a sexually transmitted infection? If yes, which one? _____	Are your parent(s)/guardian(s) aware of your visit to Family Planning
		CLIENT SIGNATURE
		TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.
		X _____ Date _____

♥ **Babies Born Healthy** These health issues are important for having a healthy baby as well as maintaining your own health.

Comments/Notes: _____

LMP: _____ G/P/A: _____ Staff Signature: _____

LAB	Result	Initials	LAB	Results	Initials
BP			Urine:		
HT			Glucose		
WT			Leukocytes		
Temp.			Nitrates		
Pulse			Protein		
HCG (P.T.)			Hgb.		

Time In: _____ Time Out: _____

	Normal	Variant	Notes		Specimen Site	Declined	Result	Cervical/Vaginal Microscopic	Results
1 Neck/Thyroid								Clue Cells	
2 Heart				Pap				Trich	
3 Lungs				HPV				Hyphae	
4 Breasts				Chlamydia				Buds	
5 Back				GC				Amine	
6 Abdomen/Trunk				Herpes				pH:	
7 Extremities				HIV				#WBCs/HPF	
8 Perineum/Vulva									
9 Vagina									
10 Cervix									
11 Uterus									
12 Adnexa									
13 Rectum									
15 Skin									

Subjective: _____

Assessment: _____

I spent _____ minutes with the patient today with more than _____% of the time spent counseling regarding _____.

Plan: _____

Education Provided:	Discussed/Materials Provided	Staff Initials

Medications/Supplies Dispensed: _____

RTC _____ PROVIDERS SIGNATURE: _____ Date: _____