

## COMPONENTS OF A FAMILY PLANNING VISIT

### I. INTRODUCTION

Delegate agencies must ensure that medical care services are provided under the supervision of a site medical director who is licensed and qualified physician with training and experience in family planning.

If colposcopy and related services (cryotherapy, excisional, biopsy) are provided on site, the Maryland Family Planning and Reproductive Health Program requirements for colposcopy services and quality assurance must be met (See Colposcopy Services and Quality Assurance Guideline).

The frequency and extent of investigation of the individual components are dependent on the type and frequency of each family planning visit, reason(s) for the visit, contraceptives in use and/or being considered for use and findings from the physical examination and laboratory testing. Similarly, revisits should be individualized based on the patient needs and the reason for the visit.

### II. HISTORY

The initial comprehensive visit must include a complete medical history. Pertinent components of this history must be updated at subsequent clinical visits.

#### A. General History

1. Reason for visit
2. Age
3. Allergies- Drug, latex, food and seasonal
4. Current medications/vitamins/herbs
5. Current method(s) of contraception
6. Previous method(s) of contraception
7. Current primary care clinician

#### B. Sexual History

1. Age of onset
2. Number of partners in lifetime
3. Number of new partners since last visit
4. Number of current partners
5. Partner infection history
6. Gender of partners
7. Types of sex acts
8. High-risk behavior
9. Date of last vaginal intercourse

#### C. Obstetric History

1. Gravidity
2. Parity
3. Abortions (spontaneous or elective)
4. Preterm births
5. Living children
6. Delivery type(s)

7. Complications
  8. Date of last delivery / date of last pregnancy termination
  9. Breastfeeding
- D. Gynecologic History
1. Last menstrual period
  2. Menarche
  3. Length of cycle
  4. Length of flow
  5. Reproductive tract infection history: including abnormal Pap, HPV, HSV, gonorrhea, chlamydia, syphilis, bacterial vaginosis, trichomoniasis
  6. Surgery
- E. Current or Past Medical History
1. Asthma
  2. Cardiovascular disease
  3. Liver disease
  4. Kidney disease
  5. GI disease
  6. Headaches
  7. Diabetes mellitus
  8. Thromboembolic disease
  9. Coagulopathies
  10. Cancer: ovary, breast, uterus, cervix
  11. Mental health disorders
  12. Other medical problems
- F. Infectious Disease History
1. Hepatitis B and C
  2. HIV
  3. Tuberculosis
- G. Social History
1. Alcohol
  2. Smoking
  3. Drug use
  4. Domestic violence
  5. Sexual abuse/assault
  6. Child abuse
- H. Family History
1. Heart disease
  2. Diabetes
  3. Addictions
  4. Cancer (ovary, breast, uterus)

### III. PHYSICAL EXAMINATION

The initial comprehensive visit must include a complete physical examination to include at least the following:

- A. Blood pressure
- B. Weight
- C. Height
- D. BMI

- E. Thyroid
- F. Heart
- I. Lungs
- J. Breasts
- K. Abdomen
- L. Extremities
- M. Pelvis
- N. Rectum (if indicated by age or risk)
- O. Skin

#### IV. COUNSELING

All clients should receive counseling on: STI/HIV transmission prevention (and should be offered screening); the importance of routine health maintenance screening procedures (and should be offered screening); methods to avoid unintended pregnancy; and on the importance of preconception care.

- A. The initial comprehensive visit must include counseling on the following:
  - 1. Importance of routine exams for preventative health maintenance:
    - a. Blood pressure evaluation
    - b. Breast exam
    - c. Pelvic exam
    - d. Pap smear
    - e. Colo-rectal screening (in individuals > 40)
    - f. STI screening including HIV
  - 2. Preventing unintended pregnancy
    - a. Abstinence/postponing sexual involvement
    - b. Contraceptive options
    - c. Emergency contraception
  - 3. Importance of preconception care and counseling
  - 4. Sexually transmitted infections/ HIV transmission
    - a. Partner selection
    - b. Barrier protection
- B. The following items should be included as indicated by history and physical exam:
  - 1. Weight/Diet/Nutrition
  - 2. Vitamins and Minerals
    - a. Iron
    - b. Folic acid
    - c. Calcium
  - 3. Exercise
  - 4. Psychosocial
    - a. Personal goals
    - b. Behavior/learning disorder
    - c. Abuse/neglect
    - d. Interpersonal/Peer/Family relationships
    - e. Family involvement
    - f. Domestic violence
    - g. Depression/Suicide
    - h. Lifestyle/Stress
  - 5. Health/Risk behaviors

- a. Substance abuse (drugs, tobacco, alcohol, prescription medications)
- b. Excess ultraviolet light
- c. Tattoos/Body piercing

V. LABORATORY TESTING

Laboratory tests should be provided as required by results of history, physical examination, and counseling components of visit. Specific laboratory testing may also be required for the provision of specific methods of contraception (refer to specific method guidelines).

The following laboratory tests must be available:

- A. Hgb/Hct
- B. Rubella screen
- C. Hepatitis B screen
- D. HIV
- E. STS
- F. VDRL or RPR
- G. Urine dipstick
- H. Pap
- I. GC
- J. Chlamydia
- K. HPV
- L. Urine pregnancy test (on site)

REFERENCES

1. ACOG. *Precis: Primary and Preventive Care*. 3rd Ed., 2004
2. Hatcher RA et al. *Contraceptive Technology*. 19th Revised Edition. Ardent Media, Inc., New York, 2007