

FAMILY PLANNING FLOW RECORD

Name _____ D.O.B _____

DATE				
Reason for visit				
Contraception used				
LNMP				
Last intercourse				
B/P				
Weight				
BMI				
Urine P/G				
Urine hCG				
PAP				
HPV				
Chlamydia				
GC				
STS				
HIV				
Hgb/Hct				
Abd pain				
Chest pains				
Headaches				
Eye problems				
Severe leg pain				
Irregular bleeding				
Smoking/amount				
Current medications				
Allergies				
CHN signature				
POST/CONF				
Contraception/amt				
Other medications				
RTC date				
Reason				
CHN signature				