

FAMILY PLANNING INITIAL RECORD

Name \_\_\_\_\_

Age \_\_\_\_\_ Race \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Allergies** \_\_\_\_\_

Current Method of Contraception \_\_\_\_\_

Current Medications (prescription, OTC, vitamins, herbal) \_\_\_\_\_

**Reason(s) for Visit** \_\_\_\_\_

**OBSTETRIC HISTORY**

Total # Preg	Full Term	Premature	Induced Abs	Spon Abs	Ectopics	Multiple Births	Living
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Date of last delivery \_\_\_\_\_ Breastfeeding now  yes  no

Cesarean # \_\_\_\_\_ Indication(s) \_\_\_\_\_

Pregnancy Complications \_\_\_\_\_

Planning pregnancy in the next 12 months  yes  no

**GYNECOLOGIC HISTORY**

1<sup>st</sup> day last menstrual period \_\_\_\_\_ 1<sup>st</sup> day prior menstrual period \_\_\_\_\_

Usual duration of flow \_\_\_\_\_ # days length of cycle \_\_\_\_\_

Pain with periods  yes  no DES exposure  yes  no

Prior contraception use  OCs  DMPA  IUD  Implant  Condoms  Other \_\_\_\_\_

Date of last Pap \_\_\_\_\_ Results \_\_\_\_\_

Colposcopy/Abnormal Pap(s)/Rx \_\_\_\_\_

GYN cancer/Surgery/Hospitalization \_\_\_\_\_

**SEXUAL HISTORY**

Ever had sexual intercourse  yes  no Age of 1<sup>st</sup> intercourse \_\_\_\_\_

Type of sex  vaginal  oral  rectal # of lifetime sexual partners \_\_\_\_\_

Sexual partners  men  women  both Sexually active now  yes  no

Date of last sexual activity \_\_\_\_\_  vaginal  oral  rectal

Length of time with current partner \_\_\_\_\_

Condom use  always  sometimes  never

New sexual partner in the last 3 months  yes  no

2 or more sexual partners in the last year  yes  no

History of STD in the last year  yes  no (list in Infectious Disease History)

Any concern about a possible STD now  yes  no \_\_\_\_\_

Exchange of sex for drugs or money  yes  no

Illicit, street, or recreational drug use  yes  no

Sex partner: with STD in the last year  yes  no Name of STD \_\_\_\_\_

with IV drug use  yes  no

with exchange of sex for drugs or money  yes  no

with admittance to jail or other detention facility  yes  no

is male having sex with men  yes  no

with other high-risk behavior  yes  no \_\_\_\_\_

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**INFECTIOUS DISEASE HISTORY**

Chlamydia \_\_\_\_\_ HPV \_\_\_\_\_ Hepatitis \_\_\_\_\_  
Gonorrhea \_\_\_\_\_ Herpes \_\_\_\_\_ HIV \_\_\_\_\_  
Trichomoniasis \_\_\_\_\_ Syphilis \_\_\_\_\_ Other \_\_\_\_\_  
TB exposure \_\_\_\_\_

**SOCIAL HISTORY**

Alcohol (# drinks/wk) \_\_\_\_\_ (age begun) \_\_\_\_\_  
Smoking (# cig/day) \_\_\_\_\_ (age begun) \_\_\_\_\_  
Illicit, street, or recreational drug use (type/frequency/age onset) \_\_\_\_\_  
Sexual assault/domestic violence  yes  no \_\_\_\_\_  
Sexual coercion  yes  no \_\_\_\_\_  
Child abuse/neglect/sexual abuse  yes  no \_\_\_\_\_  
Parental involvement  yes  no  encouraged \_\_\_\_\_

**PAST MEDICAL HISTORY**

Heart disease \_\_\_\_\_ Headaches/migraine \_\_\_\_\_  
Hypertension \_\_\_\_\_ Seizures \_\_\_\_\_  
Stroke \_\_\_\_\_ Kidney disease/UTI \_\_\_\_\_  
Blood clots (lungs/legs) \_\_\_\_\_ Gastrointestinal \_\_\_\_\_  
Anemia \_\_\_\_\_ Hepatitis/liver disease \_\_\_\_\_  
Blood transfusions \_\_\_\_\_ Lung/TB/asthma \_\_\_\_\_  
Diabetes \_\_\_\_\_ Thyroid \_\_\_\_\_  
Breast Cancer \_\_\_\_\_ Eating disorders \_\_\_\_\_  
Other Cancer \_\_\_\_\_ Injuries \_\_\_\_\_  
Operations/other hospitalization \_\_\_\_\_  
Immunodeficiency \_\_\_\_\_  
Mental health \_\_\_\_\_  
Other \_\_\_\_\_  
Immunizations HBV \_\_\_\_\_ Rubella \_\_\_\_\_

**FAMILY HISTORY**

Heart disease \_\_\_\_\_ Breast cancer (with age onset) \_\_\_\_\_  
Hypertension \_\_\_\_\_ GYN cancer \_\_\_\_\_  
Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_  
Blood clots \_\_\_\_\_ Other \_\_\_\_\_

**COMMENTS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Interpreter Name \_\_\_\_\_

Staff Signature \_\_\_\_\_

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Name \_\_\_\_\_

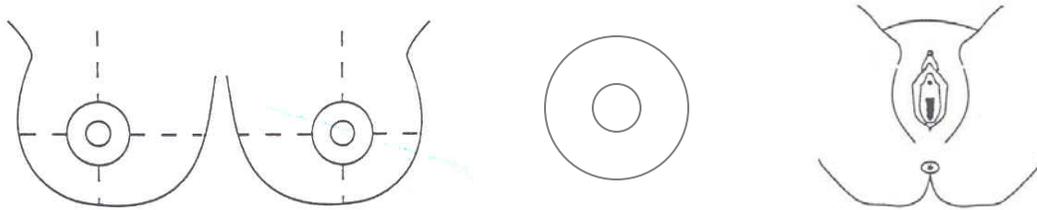
**SUBJECTIVE** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PHYSICAL EXAM** BP \_\_\_\_\_ Wt \_\_\_\_\_ Ht \_\_\_\_\_ BMI \_\_\_\_\_ UCG \_\_\_\_\_

NORMAL			NORMAL		
HEAD			VULVA		
NECK			VAGINA		
HEART			CERVIX		
LUNGS			UTERUS		
BREASTS			ADNEXA		
ABDOMEN			RECTAL		
EXTREMITES			OTHER		

PAP  HPV  CT  GC  HSV  OTHER \_\_\_\_\_

WET MOUNT \_\_\_\_\_



**COMMENTS** \_\_\_\_\_  
 \_\_\_\_\_

**ASSESSMENT** \_\_\_\_\_  
 \_\_\_\_\_

**PLAN** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RETURN VISIT** \_\_\_\_\_ **Chaperone Signature** \_\_\_\_\_

**Date** \_\_\_\_\_ **Interpreter Name** \_\_\_\_\_

**Clinician Signature** \_\_\_\_\_