Planned Parenthood Association of the Mercer Area

Patient Registration Form
Regestación Para Paciente

Patient#/# del paciente_____

Please complete the following form. All the information is confidential.
Por favor complete la hoja seguida. Toda la información es confidencial.

First Name
Primer Nombre _____
Last Name
Apellido _____
Address
Dirección _____
County
Condado _____
City
Ciudad _____
State
Estado _____
Zip
Código Postal _____
SS#
de Seguro Social _____-____-_____
Date of Birth
Fecha de Nacimiento _____/_____/_____

House Hold Income
Ingreso de la casa $_____.____
Yearly ❑ Anual
Monthly ❑ Mensual
Weekly ❑ Semanal

Family Size
Cuantos son en tu Familia _____
How many are children(s)
Cuantos son niño(s) _____

Home phone
Numero de teléfono (____)____-_____
Work phone
Numero del trabajo (____)____-_____
Emergency contact Phone number
Numero de contacto de emergencia (____)____-_____
Emergency contact Name
Nombre del contacto de emergencia _____

Please check one of the four ways you want to receive you mail from us (PPAMA)
Por favor marque una de las cuarto maneras que tu querré recibir corresponda de nosotros (PPAMA)

Full return address ❑ Dirección completa dé retorno
Street address ONLY ❑ Solamente la dirección de la calle
NO return address ❑ SIN dirección
NO mail ❑ Ninguna respeta

Please check one of the four ways you want to receive phone calls from us (PPAMA)
Por favor marque una de las cuarto maneras que tu querré recibir llamas de nosotros (PPAMA)

Saying Planned Parenthood ❑ Diciendo Planned Parenthood
Saying Doctor's Office ❑ Diciendo oficina de doctor
Saying it's a friend ❑ Diciendo que es una amiga
NO calls ❑ Ninguna llamadas

Please check all that apply
Por favor marque todo que aplica

Sex Female Male
Sexo - ❑ Femenino ❑ Masculino

Race American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Pacific Islander White
Raza - ❑ Indio Americano o Nativo de Alaska ❑ Asiático ❑ Moreno o Americano Africano ❑ Nativo Hawaiano o Isleño Pacifico ❑ Blanco

Hispanic Yes – Hispanic or Latin Not – Hispanic nor Latin Unknown
Hispano - ❑ Si – Hispano o Latino ❑ No – Hispano o Latino ❑ No sabes

Marital Status Divorced Living together Married Separated Single Widowed
Estado Marital - ❑ Divorciada ❑ Viven juntos ❑ Casada ❑ Separada ❑ Soltera ❑ Viuda

Referral Family o Friend Hospital Hot Line Media Other patient Phone book
Referido - ❑ Familia o Amiga ❑ Hospital ❑ Línea Abierta ❑ Medio de comunicación ❑ Otra paciente ❑ Libro de teléfono
Outreach Private Doctor Welfare
❑ Alcance ❑ Médico privado ❑ Welfare

Language English Other
Idioma - ❑ Ingles ❑ Otro _____
Interpreter Needed
❑ Necesito un Interprete

Student Yes No
Estudiante - ❑ Si ❑ No
Highest grade f school you completed
Grado mas alto que ha completado en la escuela _____

Planned Parenthood Association of the Mercer Area

EVALUACION DE EMBARAZO – FORMA PARA EL EXPEDIENTE MEDICO
PREGNANCY EVALUATION MEDICAL HISTORY FORM

Fecha/Date: _____ **Nombre/**Name: _____

Numero del expediente/Chart #: _____

Fecha de nacimiento/Date of Birth: _____

Breve Historia Medica/Brief Medical History

1. **¿Cuál es la fecha del primer dia de su ultima periodo que le haya bajado normal?** _____
   When was the first day of your last normal menstrual period (date)? _____
   a. **El periodo fue/**This period was: ☐ **a tiempo/**on time ☐ **se adelanto/**early ☐ **se retraso/**late
   b. **El flujo de sangre fue/**The amount of bleeding was: ☐ **normal/**normal ☐ **liviano/**lighter ☐ **fuerte/**heavier
   c. **Sus ciclos mensuales/**Are your cycles: ☐ **regulares/**regular ☐ **irregulares/**irregular
2. **Por favor marque los síntomas que usted ha tenido recientemente:**
   Please check off any symptoms that you have noticed recently:
   ☐ **Náusea/**Vomiting ☐ **Fatiga/**Excess fatigue ☐ **Inflamación del abdómen/**Swelling in abdomen
   ☐ **Orina con mas frecuencia/**Increased Urination ☐ **Fiebre o escalofrios/**Fever or chills
   ☐ **Sensibilidad/hinchazón de los senos/**Breast tenderness/swelling
   ☐ **Dolor abdominal severo o persistente/**Severe or persistent abdominal pain
   ☐ **Dolor en los hombros/**Shoulder pain ☐ _____ Spotting or Bleeding
3. **¿Ha tenido relaciones sexuales sin protección desde su último periodo?** ☐ **No** ☐ **Si/**yes **Cúando:** _____
   Have you had unprotected sex since your last period? If yes, last date:_____
4. **Esta usando algún método de anticonceptivo.** ☐ **No** ☐ **Si/**yes **Cual:** _____
   Are you currently using a method of birth control If yes, what type:_____
5. **Esta planiando un embarazo actualmente.** ☐ **No** ☐ **Si/**yes
   Were you planning a pregnancy at this time?
6. **Anteriormente ha tenido otros embarazos/** Have you been pregnant before? ☐ **No** ☐ **Si/**yes
   Si ha estado embarazada por favor indique la(s) fecha(s): If yes, please indicate the dates of:
   Partos vivos/Live births _____ **Abortos Naturales/**Miscarriages _____
   Abortos provocados/Abortions _____ **Embarazos ectópicos/**Tubal pregnancies _____
7. **Por favor mencione los problemas médicos que tiene o ha tenido:** _____
   Please list current or continuing medical problems: _____
8. **Ha tenido: Gonorrea, clamydia, infección en el útero/tubos (PID), o alguna infección después de un aborto o parto.**
   Have you ever had: gonorrhea or Chlamydia, an infection in your uterus/tubes (PID), or an infection after an abortion or delivery?
   ☐ **No** ☐ **Si/**yes **Si, por favor especifiqué** _____
   If yes, please explain: _____
9. **Mencione los medicamentos o vitaminas que esta tomando,** _____
   Please list any medications or vitamins you are currently using _____
10. **Estas usando algún tipo de drogas.** ☐ **No** ☐ **Si** **Cuando:** _____
    Are you taking any street drugs? ☐ No ☐ Yes If yes, which ones? _____
11. **Ha tomado algún medicamentos o has usado drogas en las últimas 24 horas.** ☐ **No** ☐ **Si** **Cuando:** _____
    Have you taken any medicines or drugs in the last 24 hours? ☐ No ☐ Yes If yes, which ones? _____

Firma del Paciente/Patient Signature: _____

Lab Notes

Date: _____ Type of Test: _____

Result: _____ Technician Signature and Title: _____

SOLO PARA PERSONAL – NO ESCRIBE DEBAJO DE ESTA LINEA

Nombre/Name: _____

Numero del paciente/Chart #: _____

Fecha de nacimiento/Date of Birth: _____

Counseling Notes:

Folic Acid Information given ☐ Folic Acid Given ☐ 400mg or ☐ 800mg or ☐ RX

Patient offered Urine GC/Chlamydia testing ☐ accepted ☐ declined

Trust In Yourself Information Sheet Given to patient ☐

Positive Test

Number of Weeks since LMP: _____

Continuing Pregnancy

_____Folic Acid Information Provided

_____Patient given Folic Acid ☐ 400mg or ☐ 800mg or ☐ RX

_____Patient reminded of need for pelvic exam within 30 days

_____Explained risk of drugs, alcohol, smoking, and X-rays

_____Patient offered referral for prenatal care elsewhere. Referred to _____

_____Patient undecided about where to access care. Three referrals provided:

1._____ 2._____ 3._____

_____Patient interested in adoption. Adoption information and referrals provided.

Abortion

_____Patient reminded of the need for pelvic confirmation within 7 days

_____Surgical and Medical Abortion options explained to patient

_____Patient requested referral for termination of pregnancy. Referred to_____

_____Patient undecided about where to access care. Three referrals provided:

1._____ 2. _____ 3._____

How is the client feeling about her decision?

_____Confident and clear about decision to have the abortion

_____Sad / angry / afraid / ambivalent feelings but clear about decision

_____Support System assessed

_____Referred for additional Counseling.

Undecided

_____Patient referred for an additional Options Counseling session. Referred to:_____

_____Patient reminded the importance of making a decision within the appropriate time frame

_____Patient provided with PPAMA phone number and counselor name.

_____Patient support system assessed

_____Folic Acid Information Provided

*If patient is under <18 years old, will they need assistance disclosing this pregnancy to a parent/guardian?

☐No ☐ Yes

Negative Test

Desires Pregnancy

_____Natural Family Planning information provided

_____Folic Acid Information Provided

Does Not Desire Pregnancy

_____Contraceptive information provided and discussed with patient

_____STI information provided and discussed , Urine GC/Chlamydia Testing offered ☐ Accepted ☐ Declined

_____Patient explained the need for a repeat test in 7-10 days if normal menses does not ensue

_____Patient offered a family planning visit if not currently using birth control

_____Patient offered condoms and spermicide

_____Patient selected other provider from whom she plans to seek follow-up care

Signature and Title: _____