Planned Parenthood®
Care. No matter what.
Planned Parenthood of Maryland

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Client's Name: ____

DOB: ______________________ Date: ____________________

HOPE (Hormonal Options Without Pelvic Exam)

Your Age: ______ First day of your last period: ____________ Was it normal? ☐ Yes ☐ No

Yes	No	GENERAL QUESTIONS ABOUT YOU
		Are you allergic to: ☐ latex ☐ medication (please list) ____________________________________
		Do you hope to ever have (more) children? If yes, when? ☐ More than one year ☐ Less than one year ☐ Unsure ♥

BIRTH CONTROL HISTORY

What birth control method are you currently using? _______________ Which method would you like to use? _______________

Yes	No	
		Have you ever used birth control pills, patch, vaginal ring, Depo-Provera, Lunelle, Norplant, IUC, Diaphragm or Implanon? If yes, which did you use (include the name of the pill if you know it)? ____________________________________ Any problems with these methods? ☐ Yes ☐ No If yes, describe: ______________________________________

MEDICAL/SOCIAL HISTORY

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
		Heart attack or stroke			High blood pressure ♥			Gall bladder disease
		Heart valve problems ♥			High cholesterol			Vaginal muscle problems
		Blood clots (Leg/Lung/Brain)			Migraines *			Frequent constipation
		Liver problems			Eating disorder ♥			Severe long-term depression ♥
		Lupus			Diabetes ♥			Bariatric (weight loss) surgery
		Seizures ♥			Osteoporosis/fragility fracture			Breast Cancer

Yes	No	
		Are you taking any medications (drugs, vitamins, birth control, over the counter medication, and herbal medication)? ♥ If yes, please list: ____
		Do you smoke cigarettes, cigars, pipes, or chew tobacco? How many per day? ______ How many years? ________♥
		Are you planning major surgery that will require long-term bed rest?
		Have you had any other serious illness/surgery?

Yes	No	FAMILY HISTORY
		Has your father, mother or sibling had a heart attack or stroke before 65?
		Has a family member (father, mother, brother, sister) had a serious blood clot (DVT) or blood clotting disorder?

Yes	No	GYN/SOCIAL HISTORY
		Does your period come every month?
		Do you have any problems with your period? If yes, what? ____________________________________
		Have you ever had a PAP test? Date: ______________ Was it normal? ☐ Yes ☐ No ☐ Unsure
		Do you now or have you ever had a breast lump or mass that needed to be evaluated?
		Last breast exam was normal? ☐ Never had a breast exam If not normal, please explain: ____
		Are you over 40? If so, have you had a mammogram in the past year? ☐ Yes ☐ No If yes, was it normal? ☐ Yes ☐ No If not normal, please explain:
		Are you breastfeeding now?
		Are you having sex? ☐ Oral ☐ Vaginal ☐ Anal How many sex partners have you had in the last 12 months? _______
		Have you had a new sex partner(s) within the past 3 months? If yes, how many? ______
		Do you use condoms? ☐ Always ☐ Sometimes ☐ Never Do you have sex with: ☐ Men ☐ Women ☐ Both ☐ Trans?
		Have you had sex without birth control/condoms since your last period?
		Do you or your partner(s) use IV drugs?
		Have you ever had an STI? If yes, circle all that apply: Chlamydia, Gonorrhea, Genital Warts, Hepatitis B, Hepatitis C, Herpes, HIV/AIDS, Molluscum, Syphilis,Trich(omoniasis)
		Do you think you could be pregnant now?

*Review Headache Questionnaire

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Relationship and Safety				
Violence and sexual abuse are common in many people's lives. There is help for you if you are being hurt or abused. (Note: PPM is required to report cases of child abuse or neglect that occurred as a minor, even if you are now over age 18.)				
	NEVER	**SOMETIMES**	**OFTEN**	**DECLINE**
Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?				
Does your partner refuse to use condoms when you ask?				
Has your partner ever tried to force or pressure you to become pregnant when you didn't want to be?				
Are you afraid your partner will hurt you if you tell him or her you have an STI and they need to be treated?				
Have you ever been physically or emotionally abused by your partner or someone important to you?				
Have you been hit, slapped kicked or otherwise physically hurt by someone in the past year or, if you're pregnant since you've been pregnant?				
Has anyone forced you to have sex in the past year?				
Are you afraid of your partner?				

Yes	No	
		Are your parent(s)/guardian(s) aware of your visit to Planned Parenthood of Maryland?

CLIENT SIGNATURE – TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.

X____ Date: ______________________

****** Staff Use Only ******

SUBJECTIVE (HPI/PFSH) – *Brief HPI & Complete PFSH*

HCA COMMENTS

____

____

____

____

____

□ Hx Reviewed HCA Signature:____ Date:________________

CLINICIAN COMMENTS

____

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____

____

____

____

□ Hx Reviewed Clinician Signature:____ Date:________________________

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DOB: ______________________ Date: ____________________

OBJECTIVE (PE)				
Ht.	Wt.	BMI	BP	**UPT:** ☐ Pos ☐ Neg ☐ NA
G_____ P_____ A (S) _____ /(T) _____ L_____	☐ A & O x 3 ☐ NAD ☐ Apparent distress: _________________	**Depo Injection** Lot# ________________ Exp date____________ RTC: _________________ ☐ IM ☐ SUB Q	**Rapid HIV** ☐ Neg ☐ Prelim Pos ☐ Indetermin ☐ Declined	**LABS SENT OUT:** ☐ Chlamydia ☐ GC ☐ Other ___________________ ☐ Declined

ASSESSMENT		
Yes	No	
		Appropriate for hormonal contraception?
		Appropriate for immediate use of EC?
		Smoker?
		Any special conditions? If yes, what? ___________________________________
		Needs referral for further medical evaluation: _____________________________
		Appropriate for STI screening?
Other:		

Education Done &/or Literature Given

CIICs/CIs provided in language other than English: ❑ Spanish

☐ Nutrition _______________
☐ Exercise

Client Information for Informed Consents (CIICs)* & Instructions
☐ The Pill, The Patch, The Ring
☐ Special Considerations
☐ DMPA
☐ EC
☐ POPs
☐ Implants
☐ IUC
☐ RX Barriers
☐ Breast Health- What You Can Do

Other CIICs:
☐ ____________________
☐ ____________________
☐ ____________________

Other:
☐ Safety Card Given
☐ HPV Vaccine Information Given

Client Information (CIs)*
☐ Instructions: Pills
☐ Instructions: Patches
☐ Instructions: Rings
☐ Male/Female Condoms
☐ Preg Testing, Eval & Options
☐ Spermicide for Birth Control
☐ Smoking Cessation
☐ Calcium & Vitamin D
☐ Getting Enough Calcium
☐ Iron-Rich Foods
☐ Tips for Losing Weight
☐ Vaginal & Vulvar Health
☐ Preventing Cardiovascular Disease
☐ Contra Choices
☐ STI Facts
☐ GYN Visit
☐ HIV
☐ HIV Negative

Other CIs:
☐_________________
☐ _________________
☐ _________________

*As of current year's MS&Gs

PLAN

☐Problem List / Medication Record updated
☐ Reproductive Life Plan discussed
☐ Condoms offered/encouraged
☐ Risks/benefits of BCM reviewed
☐ DMPA ☐104mg SQ / ☐150 mg IM q 12 wks x ______ ☐ Given today
☐ OCs __________________ Sig: 1 qd x ______ #____ today
☐ NuvaRing PV X ___ days / out ___ days x ______ #____ today, Refrigerate
☐ Ortho Evra 1 patch/wk X 3, none for 1 wk x ______ #____ today
☐ Continue BCM as directed
☐ Start: ☐ Today ☐ Day _______ p menses onset
☐ Use BUM X 7 days
☐ ECP ___________: ☐ 1.5 mg PO now. If no menses, repeat UPT in 2 wks.
☐ May refill prn x 1 yr ☐ Start BCM no later than following AM
☐ If ≥40, mammogram ☐ BRSQ Reviewed ☐ NA
☐ WWE encouraged – Due ____________
☐ Reason client has not had a WWE since last HOPE: __________________
RTC _________ for _________________
____
____
____
☐ Interpretation provided by PPM
☐ Interpretation provided by client's preferred interpreter (__________________)
Total time spent with clinician: _________
(☐ Spent >50% of the time counseling/education)

Signature:_____________________________ Date:______________

If under 18, parental involvement previously indicated encouraged

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