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 State Zip
Ciudad _____ Estado _____ Código Postal _____
SS# Date of Birth
de Seguro Social _____-____-_____ Fecha de Nacimiento _____/_____/_____

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

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

Home phone Work phone
Numero de teléfono (____)____-_____ Numero del trabajo (____)____-_____
Emergency contact Phone number Emergency contact Name
Numero de contacto de emergencia (____)____-_____ 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 Interpreter Needed
Idioma - ❑ Ingles ❑ Otro _____ ❑ Necesito un Interprete

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

Date: _____ **Patient Label:**

ABORTION SERVICES MEDICAL HISTORY

Planned Parenthood Association of the Mercer Area

Date of **Last Menstrual Period**?_____

Was this period normal? ☐ Yes ☐ No

Positive Pregnancy test? ☐ Clinic ☐ Home; Date _____

Have you ever had:

YES	NO	
☐	☐	Asthma/Lung disease/TB/Pneumonia
☐	☐	Heart disease/Heart Attack/Murmur/MVP
☐	☐	High blood pressure
☐	☐	High cholesterol/triglycerides
☐	☐	Blood clots in veins/lungs/varicose veins
☐	☐	Liver disease/Hepatitis
☐	☐	Kidney/Bladder/Urinary problem
☐	☐	Stomach/Intestinal problems/Ulcer
☐	☐	Gall bladder disease
☐	☐	Adrenal failure/insufficiency
☐	☐	Frequent Vaginal infections
☐	☐	Uterine fibroids/growth
☐	☐	Infection of Uterus or Tubes/PID
☐	☐	Breast disease/Tumor/Surgery
☐	☐	Abnormal Pap Smear
☐	☐	STI/Chlamydia/Gonorrhea
☐	☐	Stroke
☐	☐	Migraines/Frequent headaches
☐	☐	Seizures/Epilepsy/Convulsions
☐	☐	Anemia/Blood disorders
☐	☐	Thyroid problems
☐	☐	Diabetes
☐	☐	Sickle Cell Disease/Trait
☐	☐	HIV positive
☐	☐	Cancer Type _____
☐	☐	Previous Surgeries/Hospitalizations
☐	☐	Any Chronic Illness/Medical Condition

Do you have any **ALLERGIES** to the following? ☐ NONE

☐ Latex ☐ Novocain ☐ Lidocaine ☐ Iodine

☐ Aspirin ☐ Demerol ☐ Morphine ☐ Tetracycline

☐ Penicillin ☐ Other drug allergies, please list:

_____

Have you ever had **ANESTHESIA** before? ☐ Yes ☐ No

If Yes, ☐ Local? ☐ General?

Any problems with anesthesia? ☐ Yes ☐ No

Are you taking any **MEDICATIONS or DRUGS**?
(include over-the-counter medication, herbals, vitamins)
Please list:

_____ _____

_____ _____

_____ _____

Are you adopted? ☐ YES ☐ NO

If YES, skip this section:

Have your Parents/Sister/Brother/or Grandparents ever had:

YES	NO	
☐	☐	Diabetes
☐	☐	Cancer (Breast/Ovarian/Uterine/or Colon)
☐	☐	High Cholesterol/triglycerides
☐	☐	Heart attack/Heart disease
☐	☐	Stroke
☐	☐	High Blood Pressure

Social/Sexual History :

YES	NO	
☐	☐	Do you smoke cigarettes? #/day _____
☐	☐	Alcohol/Drug Use

If yes, type _____

Amount per day _____

☐	☐	Have you or any of your partners shared needles to shoot/inject drugs?
☐	☐	Would you like to discuss problems related to rape or emotional/physical/sexual abuse?
☐	☐	At any time, has your partner hit, kicked or otherwise hurt or frightened you?

Pregnancy History:

_____ Total number of pregnancies (include this one)

_____ Number of live births; Dates: _____

_____ Number of miscarriages; Dates: _____

_____ Number of abortions; Dates: _____

_____ Number of C-sections; Dates: _____

_____ Number of ectopic (tubal) pregnancies

_____ Number of living children

Are you breastfeeding? ☐ Yes ☐ No

Did you have any complications during any pregnancy?

☐ Yes ☐ No

If Yes, what? _____

The medical history I have completed is correct to the best of my knowledge.

PATIENT SIGNATURE _____ **SIGNATURE/TITLE** _____

FOR STAFF ONLY – DO NOT WRITE BELOW

Date: _____ **Patient Label:**

SURGICAL ABORTION COUNSELING ***Planned Parenthood Association of the Mercer Area***

□ All pregnancy options reviewed and discussed with patient.
□ Patient is confident and clear about decision to have abortion □ Sad /angry / ambivalent but clear about decision
□ Client informed about what to expect emotionally and physically before, during, and after abortion including that a range of emotions is normal
□ Support System assessed □ Client Offered additional resources (i.e. Exhale #, Backline #, other)
□ Client @ potential Risk of poor coping due to : _____
□ Client referred to social worker/elsewhere for additional assessment/counseling □ Client decided to defer or delay the abortion.
□ Request for Medical Services, reviewed and discussed, signed by patient.
□ Request for Surgery or Special Procedure given, reviewed and discussed with patient, signed and a copy offered.
□ In-Clinic Abortion-Suction CIIC reviewed and discussed w/ patient .Patient signed and copy offered. (Questions concerning risks of surgical procedure answered.)
□ Patient contact information reviewed for accuracy.
Rho (D) Immune Globulin information form given, reviewed and discussed □ YES □ NO □ Not Applicable
□ Vital signs taken and documented below.
□ Current medications and allergies documented below. Pregnancy history documented below.
□ Birth Control Methods reviewed and discussed.
Method Selected: _____ □ Informed Consent given and signed.
□ Local anesthetic discussed.
Previous experience with lidocaine? □ YES □ NO Allergic to lidocaine? □ YES □ NO
□ GC/Chlamydia testing offered. Patient : □ Accepted □ Declined
□ Patient's method of transportation home _____
□ Follow-up appointment scheduled for _____
□ Payment: Amount collected documented on super bill OR insurance copied and attached to super bill and lab form.
Staff Notes: _____

_____

Date _____ **Signature, Title** _____

PHYSICAL EXAMINATION □ **EXAM DEFFERED**

Hgb _____ Rh Status _____ Ht. _____ Wt. _____ B/P _____ Pulse _____ Temp. _____

G _____ P _____ A _____ M _____ C-sec _____ Ectopic _____

Allergies _____ Current Medications _____

General _____ External
Heart □ Normal _____ Genitalia □ Normal _____

Lungs □ Normal _____ Vagina □ Normal _____

Abdomen □ Normal _____ Cervix □ Normal _____

Breast □ Normal _____ Adnexa □ Normal _____

Uterus Size: _____
Position □ Mid □ Anteverted □ Retroverted

Pap Obtained Today □ Yes □ No
Osmotic Dilators(s) used □ Yes □ No Misoprostol used buccal/oral/vaginal □ Yes □ No
Comments: _____

_____

Date _____ **MD Signature** _____