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 _____

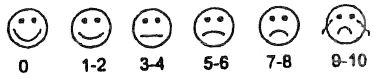
Planned Parenthood of the Mercer Area **Patient Label**

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

ANNUAL/REVISIT HISTORY / MALE

Date: _____ Allergies: _____

Reason for today's visit: _____

Yes	No	Medical History Are you experiencing?	Staff Use Only	Yes	No	Current Health Practices Do You
		1. Unusual discharge from the penis?				12. Smoke cigarettes: Amount/day _____
		2. Pain, burning or difficulty with urination?				13. Use alcohol: Amount/week _____
		3. Frequent urination or blood in urine?				14. Use street drugs: Type
		4. Pain or bleeding with sex or ejaculation?				**SINCE YOUR LAST VISIT HAVE YOU HAD:**
		5. Rectal pain, bleeding or discharge?				15. Illness, surgery, hospitalization
		6. Bumps or sores on your penis or genital area?				16. Jaundice (yellow skin or eyes), hepatitis, mononucleosis
		7. Have you recently taken antibiotics for infection?				17. Any changes in the health of close family members? (heart attack, stroke, diabetes, cancer, cholesterol, death)
		8. Have you or your partner had more than one sexual partner in the past three months?				18. Are you allegeric to any medicine? What: _____
		9. Has your partner(s) had bumps, sores or discharge in genital area?				19. Are you in pain today? Please circle re: severity 
		10. Has your partner recently been treated for a sexually transmitted disease?				
		11. Are you using condoms for every sex act?				Location of today's pain

Please list all medications or drugs you are using now or take frequently, including over-the-counter medications, herbs and vitamins _____

To the best of my knowledge, the above information is complete and accurate.

Client signature: _____ Date: _____

Physician Signature: _____ Date: _____

Planned Parenthood Association of the Mercer Area **Patient Label**

MALE EXAM FORM
FOR STAFF ONLY

Date:_____

EDUCATION INFORMATION

[ ] Abstinence discussed [ ] If 17 and under, Enc'd Parental Involvement [ ] Coercion discussed

[ ] Overview of methods/Fact sheet given [ ] Orientation brochure / TSE / EC info given [ ] HIV /STI Risk assessment reviewed. ( ) Reproductive Anatomy and Physiology reviewed
[ ] STI / HIV counseling / safer sex [ ] Risks of smoking, other substance abuse
( ) Condoms offered and given ( ) Condoms refused

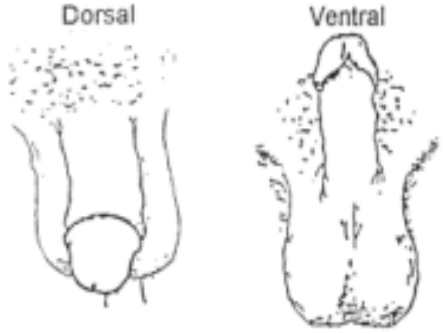
STAFF SIGNATURE:_____ Date: _____

Reason for Visit / Chief Complaint / History of Present Illness:

O: Examination / Physical Findings

System	WNL	N/D	ABN	Comments
Throat				
Neck (Thyroid)				
Heart				
Breast				
Lungs				
Pubic Area				
Inguinal Nodes				
Penis				
Scrotum				
Testes				
Anus				
Prostate				
Skin				

[ ] STE Reviewed / taught



Lab Test Done: CHL_____ GC____ VDRL_____ HIV_____

Assessment:

Rx:

PLAN:

[ ] Referral given:

Physician Signature:

Client Information for Informed Consent Given:

[ ] GC FS [ ] Doxycycline FS [ ] Post-op appt offered (Vasectomy clients) [ ] accepted [ ] declined
[ ] Trich FS [ ] Metronidazole FS [ ] Post-Vasectomy Instructions Given with after hours phone numbe
[ ] Herpes FS [ ] Zithromax FS [ ] Post-Vasectomy Semen Analysis instructions Given
[ ] HPV FS [ ] Chlamydia FS
[ ] STD Treatment w/o Exam FS [ ] Rocephin FS
[ ] Smoking Facts [ ] Other: _____
[ ] Reviewed etiology, and transmission of DX
[ ] Partner treatment encouraged Return to clinic_____

Notes:

Nurse Signature: