



HOPE Visit

(Hormonal Option Without Pelvic Exam)

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

Reason for today's visit: _____ Age: _____

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

GENERAL QUESTIONS ABOUT YOU

Yes	No	
		Are you allergic to: <input type="checkbox"/> latex <input type="checkbox"/> medication (please list) _____
		Have you ever used birth control pills, patch, vaginal ring, Depo-Provera, Lunelle, Norplant, or Implanon? If yes, which did you use (include the name of the pill if you know it)? _____ Any problems with these methods? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____
		Do you hope to have (more) children? If yes, when? <input type="checkbox"/> More than one year <input type="checkbox"/> Less than one year <input type="checkbox"/> Unsure

MEDICAL/SOCIAL HISTORY

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
		Blood clots (legs, lung, brain) ♥			High blood pressure ♥			Heart valve problems ♥
		Heart attack or stroke			High cholesterol			Gall bladder disease
		Breast cancer			Migraines *			Vaginal muscle problems
		Liver tumor or disease			Eating disorder ♥			Frequent constipation
		Hepatitis or mononucleosis			Diabetes ♥			Severe long-term depression
		Seizures ♥			Osteoporosis/fragility fracture			Other serious illness/surgery

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 much per day? _____ ♥

Are you planning major surgery that will require long-term bed rest?
For IUC (Intrauterine Contraceptive) candidates, have you ever had a vaginal delivery?

FAMILY HISTORY

Yes	No	
		Has your father or a brother had a heart attack or stroke before 55?
		Has your mother or a sister had a heart attack or stroke before 65?

GYN/SOCIAL HISTORY

Yes	No	
		Was your last period normal for you? First day of your last period: _____
		Does your period come every month?
		Have you had sex without birth control since your last period?
		Do you have any problems with your period? If yes, what? _____
		Are you currently sexually active? If yes, check all that apply: <input type="checkbox"/> New relationship <input type="checkbox"/> Long-term monogamous relationship <input type="checkbox"/> Multiple partners
		Have you ever had a PAP test? Date: _____ Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
		Do you now or have you ever had a breast lump or mass that needed to be evaluated?
		Are you over 40? If so, have you had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Are you breastfeeding now?
		Do you have any other concerns or issues? Please list: _____

Do you use condoms? Always Sometimes Never

RELATIONSHIP & 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.)

My partner has threatened or frightened me. Often Sometimes Never Decline

My partner has physically abused me. Often Sometimes Never Decline

I have been forced to have sex. Often Sometimes Never Decline

FILL OUT THIS SECTION IF YOU ARE UNDER 18 YEARS OLD

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: _____

* Give client Headache questionnaire.

♥ = **Babies Born Healthy**: These health issues are important for having a healthy baby as well as maintaining your own health.

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Client's Name: _____

DOB: _____ Date: _____

*** Staff Use Only ***

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

HCA COMMENTS

Hx Reviewed HCA Signature: _____ Date: _____

CLINICIAN COMMENTS

Hx Reviewed Clinician Signature: _____ Date: _____

OBJECTIVE (PE)

Ht.	Wt.	BMI	BP	UPT: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA
<input type="checkbox"/> A & O x 3	LABS SENT OUT:		IUC Candidate:	
<input type="checkbox"/> NAD	<input type="checkbox"/> Chlamydia		<input type="checkbox"/> Cervix dilated in labor previously	
<input type="checkbox"/> Apparent distress: _____	<input type="checkbox"/> GC		<input type="checkbox"/> Cervix <input type="checkbox"/> No CMT	
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Uterus <input type="checkbox"/> AV <input type="checkbox"/> RV <input type="checkbox"/> Mid <input type="checkbox"/> NI size	
			<input type="checkbox"/> Adnexa <input type="checkbox"/> NT	
			<i>(If bi-manual is done, code visit as LS, not HOPE.)</i>	

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

PLAN

CIICs/CIIs provided in language other than English: Spanish

Nutrition _____

Exercise _____

Client Information for Informed Consents (CIICs)*

The Pill

The Ring

The Patch

Special Considerations

HOPE

DMPA

EC

POPs

Implants

IUC

IUC with Special Conditions

IUC Use Beyond Recommend.

IUC in Place-Pregnant

Misoprostol for GYN Procedures

RX Barriers

Other CIICs:

Client Information (CIs)*

Male/Female Condoms

Instructions for use of Pill

Instructions for use of Ring

Instructions for use of Patch

Preg Testing, Eval & Options

Spermicide for Birth Control

Smoking Cessation

Calcium & Vitamin D

Iron-Rich Foods

Tips for Losing Weight

Contra Choices

STI Facts

GYN Visit

Other CIs:

*As of current year's MS&Gs

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: Sunday p menses onset Day _____ Today Continue

Use BUM X 7 days

Plan B: 2 tabs PO now

May refill prn x 1 yr Start BCM no later than following AM

RTC _____ for _____

WWE due _____

If under 18, parental involvement previously indicated encouraged

Interpretation provided by

PPM Client's preferred interpreter (name _____)

Total time spent with clinician: _____

(Spent >50% of the time counseling/education)

Signature: _____ Date: _____