

CLIENT INFORMATION SHEET

Legal Last Name		Legal First Name		MI
What would you like to be called:				
Address				
City		State	Zip	
Preferred Phone #	Type of phone (Circle one) Home Work Cell Pager Other_____	Alternate Phone #	Type of phone (Circle one) Home Work Cell Pager Other_____	
How should we identify ourselves when calling (Circle one) Planned Parenthood "Your Dr's Office" Other: _____		Where Did You Hear About Planned Parenthood: _____		
Type of envelopes we should use for mailings (Circle one) Planned Parenthood Logo Plain Envelope				
Social Security Number	Date of Birth	Required: Sex (Circle one) Male Female	Optional: Gender Identity (Circle one) Man Woman Other	
Primary Care Physician (PCP)			PCP Telephone #	
Emergency Contact Name	Relationship to You	Emergency Contact Phone #	Type of phone (Circle one) Home Work Cell Pager Other	
What is Your Race? (Check one or more)				
<input type="checkbox"/> American Indian	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American		
<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Pacific Islander		
Hispanic Origin? (Circle one) Yes No				
Primary Language	Secondary Language	Marital Status (Circle one) Single Married Divorced		
PRIMARY INSURANCE				
Insurance Name		Policy Holder Relationship to you: _____		
Policy Holder's Name (If other than self)		Policy Holder's Address (If other than self)		
Policy Holder's Date of Birth	Policy Holder's Social Security Number	Policy Holder's Employer		
SECONDARY INSURANCE (Fill in only if you have another insurance)				
Secondary Insurance Name		Policy Holder Relationship to you: _____		
Policy Holder's Name (If other than self)		Policy Holder's Address (If other than self)		
Policy Holder's Date of Birth	Policy Holder's Social Security Number	Policy Holder's Employer		

I certify that the above information is true, correct and complete to the best of my knowledge. I hereby assign to Planned Parenthood of Maryland (PPM) the right to any claim or reimbursement for medical services provided by their physicians and clinical staff. I understand that I am responsible for any fees which are rejected by my insurance company and for which PPM received no payment. I also permit the copying and release of medical records to the insurance company for the processing of claims related to services provided. I understand that PPM is required to report to the appropriate government agencies if they suspect I am currently the victim of child abuse or neglect or if I indicate I was a victim of child abuse or neglect when I was a minor, even if I am now over age 18.

Client Signature: X _____ **Date:** _____

Present Photo ID, Insurance Card and/or Proof of Income to Front Office Staff



Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

VOLUNTARY REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I have been given information about the test(s), treatment(s), procedure(s) contraceptive method(s), to be provided, including the benefits, risks, possible problems/complications and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood of Maryland's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Planned Parenthood of Maryland's notice of health information privacy practices.

Please note that Planned Parenthood of Maryland is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

Signature of Client **X** _____ Date _____

I witness the fact that the client received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of Witness _____ Date _____

<input type="checkbox"/> CHECK HERE IF CLIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW	
Signature of any other person consenting X _____	Date _____
Relationship to client _____	
I witness the fact that the client's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.	
Signature of Witness _____	Date _____

Client must review and sign PPMPF 112 every three years OR if the last consent signed was PPMPF 112, Rev 03/2007 or earlier.

HOPE Visit

(Hormonal Option Without Pelvic Exam)

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

Your Age: _____ First day of your last period: _____ Was it normal? Yes No

GENERAL QUESTIONS ABOUT YOU

Yes	No	
		Are you allergic to: <input type="checkbox"/> latex <input type="checkbox"/> medication (please list) _____
		Do you hope to ever have (more) children? If yes, when? <input type="checkbox"/> More than one year <input type="checkbox"/> Less than one year <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ♥			Breast cancer
		Seizures ♥			Osteoporosis/fragility fracture			Bariatric (weight loss) 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 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?

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?
		Has a family member (father, mother, brother, sister) had a serious blood clot (DVT) or blood clotting disorder?

GYN/SOCIAL HISTORY

Yes	No	
		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? <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?
		Last breast exam was normal? <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No If not normal, please explain: _____
		Are you breastfeeding now?
		Are you having sex? <input type="checkbox"/> Oral <input type="checkbox"/> Vaginal <input type="checkbox"/> 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? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never Do you have sex with: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both <input type="checkbox"/> 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, Trichomoniasis (trich)
		Do you think you could be pregnant now?

* Give client Headache questionnaire.

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

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

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

Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?
 Often Sometimes Never Decline

Does your partner refuse to use condoms when you ask?
 Often Sometimes Never Decline

Has your partner ever tried to force or pressure you to become pregnant when you didn't want to be?
 Often Sometimes Never Decline

Are you afraid your partner will hurt you if you tell him or her you have an STI and he or she needs to be treated?
 Often Sometimes Never Decline

Have you ever been physically or emotionally abused by your partner or someone important to you?
 Often Sometimes Never Decline

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?
 Often Sometimes Never Decline

Has anyone forced you to have sex in the past year? Often Sometimes Never Decline

Are you afraid of your partner? 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: _____

***** 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
G _____ P _____ A (S) _____ / (T) _____ L _____	<input type="checkbox"/> A & O x 3 <input type="checkbox"/> NAD <input type="checkbox"/> Apparent distress: _____		Rapid HIV <input type="checkbox"/> Neg <input type="checkbox"/> Prelim Pos <input type="checkbox"/> Indetermin	LABS SENT OUT: <input type="checkbox"/> Chlamydia <input type="checkbox"/> GC <input type="checkbox"/> Other _____

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: _____

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

Education Done &/or Literature Given

PLAN

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

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: 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/CBE encouraged
- WWE encouraged – Due _____
- 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