Planned Parenthood® of Maryland, Inc. | WE'RE HERE.℠

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)

	American Indian		Asian		Black/African American
	Alaskan Native		White		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 _______________________

☐ **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.

Planned Parenthood®
of Maryland, Inc.

Affix Label Here

Client's Name: ______________________

DOB: ______________ Date: ______________

Comprehensive History

Reason for today's visit:_______________________ Age: _______

Some of these questions are personal, but they help us in evaluating your health.

Yes, in the past	Yes, currently	No	
			1. Are you allergic to: ☐ latex ☐ medication (please list) ______________
GENERAL			
			2. Have you been diagnosed with Lupus?
			3. Have you been under a provider's care for any illness or chronic condition? If yes, describe: ______________
			4. Are you taking any medications (drugs, vitamins, over the counter medication, and herbal medication)? If yes, please list: ______________ ♥
IMMUNIZATIONS ♥			
			5. Hepatitis B ☐ shot 1 ☐ shot 2 ☐ shot 3
			6. HPV ☐ shot 1 ☐ shot 2 ☐ shot 3
			7. Rubella/MMR
			8. Chicken Pox (☐ Disease / ☐ Vaccine)
			9. Tetanus/ Pertussis
CARDIOVASCULAR			
			10. High Blood Pressure ♥
			11. High Cholesterol / Triglycerides
			12. Heart Disease/Murmur/Mitral Valve Problems ♥
NEUROLOGIC			
			13. Stroke ♥
			14. Migraine *
			15. Seizures/Epilepsy ♥
GASTROINTESTINAL			
			16. Irritable Bowel Syndrome or Crohn's Disease
			17. Liver Disease / Jaundice / Hepatitis
			18. Gall Bladder Disease
ENDOCRINE ♥			
			18. Diabetes
			19. Thyroid Problems
RESPIRATORY ♥			
			20. Asthma / Tuberculosis / Chronic Cough
GENITOURINARY			
			21. Uterine Abnormality / Fibroids ♥
			22. Endometriosis ♥
			23. Pelvic Infection/Pain/PID ♥
			24. Breast Discharge/Lump ♥
MUSCULOSKELETAL			
			25. Broken Bones/ Osteoporosis ♥
MENTAL HEALTH ♥			
			26. In Counseling
			27. Depression/Anxiety/Bi-Polar
			28. Suicide Attempt
			29. Eating Disorder
HEMATOLOGIC ♥			
			30. Anemia
			31. Blood Clotting Disorder (Leg/Lung/Brain)
			32. Sickle Cell Anemia/Trait/ Thalassemia

HOSPITALIZATIONS / SURGERIES

Year	Reason

FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No ☐ I do not know my family history.

Has your parent, sibling or grandparent had any of the following?

Yes	No	Diagnosis	Relative
		Cancer (Breast, Ovarian, Uterine, Colon)	
		Diabetes	
		Genetic Problems	
		High Blood Pressure	
		High Cholesterol or Fats	
		History of Blood Clotting Disorders	
		Other:	
		Father or brother with heart attack/stroke before age 55	
		Mother or sister with heart attack/stroke before age 65	

SOCIAL HISTORY ♥

Yes	No	
Nicotine, Alcohol, and/or Drug Use		
		Smoke cigarettes, cigars, pipes, or chew tobacco How much per day? __________
		Drink alcohol (beer, wine, liquor) -- ____ drinks per week
		Do you or your partner use street or IV drugs?
		Do you feel like you should cut down or stop using alcohol/drugs?
Exercise		
		Exercise ______ times per week for _________ minutes

SEXUAL HISTORY ♥

__________ Age at first vaginal sex ☐ Never sexually active

Yes	No	
		Are you sexually active now? Check all that apply. ☐ Vaginal ☐ Anal ☐ Oral ☐ Sex toys
		Have you or your partner had a new or more than one sexual partner in the past 3 months?
		Do you protect yourself from sexually transmitted infections? If yes, how? ______________
		Do you want testing for sexually transmitted infections today?
		Have you ever had a sexually transmitted infection? If so, please check: ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Cervical HPV ☐ Hepatitis B or C ☐ Herpes ☐ HIV ☐ Syphilis ☐ Trichomoniasis ☐ Other ______________
		Do you have bleeding or pain during or after sex?

Date of last sex? ______________

Number of partners in the past 12 months? __________

Partners are: ☐ Male ☐ Female ☐ Both ☐ Trans

Please continue with form on back of this page.➔

*Give headache questionnaire.

To be filled out at first well-woman exam and every 3 years.

♥ = ***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.)

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 of 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

FAMILY PLANNING HISTORY

Check all birth control methods you have used:

☐ Pill ☐ IUC ☐ Condoms ☐ Sterilization
☐ Depo ☐ Diaphragm ☐ Patch ☐ Natural Family Plng
☐ Ring ☐ Spermicide ☐ Withdrawal/Pull out
☐ Sponge ☐ Norplant/Implanon ☐ Other ________________

Date of last sex *without* using a birth control method (including condoms): __________________

Yes	No	
		Do you or your partner use birth control now? If so, what? ______________________ How long have you used this method?____________ Are you happy with this method?__________ If no method: ☐ trying to get pregnant ☐ partner(s) is same sex ☐ other________________
		What birth control method do you want today? __________ ☐ Don't know
		Do you hope to ever have (more) children? If yes, when? ☐ More than one year ☐ Less than one year ☐ Unsure
		Are you familiar with Emergency Contraception (EC) and that you can buy it without a prescription if you are ≥ 17?

*** *Staff Use Only* ***

HCA COMMENTS

____

____ ☐ Hx Reviewed

HCA Signature:__________________________ Date:_________

GYN HISTORY

Yes	No	
		Is this your first pelvic (GYN) exam? Date of last Pap: __________
		Have you ever had an abnormal pap smear? If yes, date ____________ Treatment: ☐ Cryotherapy ☐ LEEP ☐ None Follow-up Paps: ☐ Normal ☐ Abnormal ☐ None
		Do you douche?

________ What was the first day of your last **normal** menstrual period?
________ Age periods started
Periods come every ______ days and last ______ days.
Please describe any problems you have had with your periods:
____

PREGNANCY HISTORY ☐ **never pregnant**

Yes	No	
		Are you breastfeeding now?
		Have you ever had an ectopic (tubal) or molar pregnancy?

Mo/Year	Pregnancy Result	# weeks carried	Birth weight
	☐ vaginal ☐ miscarriage ☐ c-section ☐ abortion		
	☐ vaginal ☐ miscarriage ☐ c-section ☐ abortion		
	☐ vaginal ☐ miscarriage ☐ c-section ☐ abortion		
	☐ vaginal ☐ miscarriage ☐ c-section ☐ abortion		
	☐ vaginal ☐ miscarriage ☐ c-section ☐ abortion		

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* ***

CLINICIAN COMMENTS

____

____ ☐ Hx Reviewed

Clinician Signature:__________________________ Date:_________

*Give headache questionnaire. To be filled out at first well-woman exam and every 3 years.

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