

**Pregnancy Test Visit**

Affix Label Here

Client's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_ Age: \_\_\_\_\_

What was the first day of your last menstrual period? Date: \_\_\_\_\_

Was it normal (timing, amount of bleeding)?  Yes  No

My last period was:  On time  Early  Late

The amount of bleeding was:  Normal  Lighter  Heavier

Do you protect yourself from pregnancy?  Yes  No

If yes, how? \_\_\_\_\_

Date of last sex without a birth control method: \_\_\_\_\_

Yes	No	
		Are your menstrual cycles usually monthly?
		Were you using a method of birth control when you think you may have become pregnant?
		Have you taken a home pregnancy test? If yes, when? _____ Result: _____
		Do you want to be pregnant? <input type="checkbox"/> Undecided <input type="checkbox"/> In the future
		Have you been pregnant before? If yes, # of live births _____ # of abortions _____ # of miscarriages _____ # of tubal pregnancies _____ # of still births _____
		If your pregnancy test is negative, would you be interested in starting on birth control? * <input type="checkbox"/> Undecided <input type="checkbox"/> Already on birth control _____
		Since your last period have you had any bleeding or spotting? **
		Have you had pelvic inflammatory disease ( <b>not</b> yeast, <b>not</b> bacterial vaginosis)? **
		Since your last period, have you had any <b>one-sided</b> abdominal pain? **
		Have you had a ruptured appendix? **
		Have you had a tubal ligation (tubes tied) or any other surgery on your tubes? **

**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.

Client Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

HCA:  
 \* Give client HOPE form, as needed  
 \*\* If yes and positive pregnancy test, clinician must review form prior to client discharge. Give client PPMFS 211, CI: Ectopic Pregnancy, if directed by clinician.

Affix Label Here

\*\*\* Staff Use Only \*\*\*

Client's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**SUBJECTIVE (HPI) – Brief HPI**

**HCA COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hx Reviewed HCA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CLINICIAN COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_

Hx Reviewed Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OBJECTIVE (PE)**

LMP: \_\_\_\_\_  
UPT:  Pos  Neg  Inconclusive  
If positive, EGA by LMP \_\_\_\_\_  
EGA by bi-manual \_\_\_\_\_  
EDD \_\_\_\_\_

A & O x 3  
 NAD  
 Apparent distress: \_\_\_\_\_

**LABS SENT OUT:**  
 Chlamydia  
 GC  
 Other \_\_\_\_\_

**ASSESSMENT**

- Client desires to continue pregnancy
- Client desires to terminate pregnancy
- Client desires adoption
- Undecided
- Risk factors for ectopic pregnancy
- UPT Negative

**PLAN**

- If pregnancy test was positive:**
- Options discussed and info given for
    - Prenatal care
    - Abortion
    - Adoption
  - Provided info on early prenatal care, including folic acid
  - Rx given for prenatal vitamins
  - Reviewed signs and symptoms of ectopic pregnancy and miscarriage
  - Birth control information given
  - Condoms offered / encouraged
- If pregnancy test was negative:**
- Advised to repeat UPT in \_\_\_\_\_
  - Contraception options reviewed, including abstinence
  - EC CIIC given \*\*
  - BCM (Contra Choices) information given
  - Folic acid/prenatal vitamin info given
  - Client encouraged to RTC for yearly exams, if appropriate
  - HOPE appt offered
  - Hope visit done today – see HOPE form
  - Condoms use encouraged/offered
  - If no unexplained menses x 3 months, advised follow-up
  - Preconception counseling
- CIICs/CIIs provided in language other than English:
- Spanish
- Other CIICs/CIIs/Education:
- CIIC: Pregnancy Testing, Options Couns
  - CI: Ectopic Pregnancy
  - \_\_\_\_\_

Clinician Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Hx Reviewed
- Reproductive Life Plan discussed
- 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: \_\_\_\_\_

\*\* As of current year's MS&Gs