

# PLANNED PARENTHOOD GREATER MEMPHIS REGION

## DEMOGRAPHIC DATA

Today's Date: \_\_\_\_\_ CHART NUMBER \_\_\_\_\_

Birthdate: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Sex: F / M Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Race: White Black Native American Asian Pacific Islander Other	Ethnicity: Hispanic Non-Hispanic
Marital Status: Married Single Divorced Partnered	Education Level: _____
Occupation: _____	Employer: _____

How did you hear about us? (Please choose one)			
1-Other Clinic	2- Hospital/health agency	3-Private Doctor	4-Social/Church Agency
5-School	6-Other Patient	7-Family/Friend	8-Media
9-Hotline	10-Phonebook	11-Other Public Health Program	

<b>Pregnancy Information:</b>
Number of Pregnancies: _____
Number of Births: _____
Number of Living Children: _____

<b>Emergency Contact:</b>
Who should we contact in case of an emergency ONLY?
Name: _____
Relationship: _____ Phone: _____

<b>LAB TEST RESULTS – MUST BE COMPLETED</b>
<b>Planned Parenthood MUST be able to contact you in certain situations.</b> We also want to protect your privacy and confidentiality. If it is necessary to reach you for abnormal test results, what do you want us to say when calling? <input type="checkbox"/> Planned Parenthood <b>OR</b> <input type="checkbox"/> Dr's Office <b>OR</b> <input type="checkbox"/> Heather
What do you want us to say if we call your work number? <input type="checkbox"/> Planned Parenthood <b>OR</b> <input type="checkbox"/> Dr's Office <b>OR</b> <input type="checkbox"/> Heather
Can we mail a letter to you asking that you contact us? <input type="checkbox"/> Yes <input type="checkbox"/> No
Can the envelope have Planned Parenthood's return address on it? <input type="checkbox"/> Yes <input type="checkbox"/> No

If you <b>DO NOT</b> wish to be contacted at the above address and phone number: Who can we contact? _____ Relationship to you: _____ Their address: _____ Their phone: _____
We reserve the right to send a certified letter to the address you have given if that is the only way we can notify you of abnormal test results.

<b>MUST BE COMPLETED</b>
<b>DO YOU HAVE HEALTH INSURANCE?</b>
YES NO
<b>PUBLIC OR PRIVATE</b>
INSURANCE NAME: _____

Place Patient Label Here

Planned Parenthood Greater Memphis Region  
1407 Union Suite 300  
Memphis, TN 38104  
(901) 725-1717

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

DATE \_\_\_\_\_ PATIENT # \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

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), and 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 Greater Memphis Region'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).

Planned Parenthood Greater Memphis Region  
1407 Union Suite 300  
Memphis, TN 38104  
(901) 725-1717

I hereby acknowledge receipt of Planned Parenthood Greater Memphis Region notice of health information privacy practices.

Signature of patient \_\_\_\_\_

Date \_\_\_\_\_

I witness the fact that the patient 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 PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW
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Signature of any other person consenting \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Date \_\_\_\_\_

I witness the fact that the patient'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 \_\_\_\_\_

# Planned Parenthood Greater Memphis Region

## INITIAL HISTORY

Date / / Age

**PATIENT LABEL**

A. REVIEW OF SYSTEMS:		
YES	NO	GENERAL
		1. Is your health generally good?
		2. Unexplained weight loss or gain of more than 10 lbs. in the past year?
		3. Night sweats / hot flashes?
		4. Cancer? If yes, where / when?
		5. Tobacco use? If yes, for how many years? _____ If yes, <input type="checkbox"/> smoking? How many/day? <input type="checkbox"/> chewing tobacco?
		6. Alcohol use? If yes, how many drinks/week?
		7. Are you being treated for any illness/condition now? If yes what?
		8. Do you currently take medicine: prescription, over-the-counter, or herbal? If yes, what?  Do you take any folic acid supplements?
		9. Birth defects or genetic problems?
		10. Eye problems (except glasses or contacts)?
		11. Hearing problems?
		12. Frequent nosebleeds?
		13. Frequent sore throat?
CARDIO-RESPIRATORY		
		14. Mitral valve prolapse?
		15. Heart murmur?
		16. Varicose veins?
		17. Blood clots (head / leg / lungs)?
		18. Stroke or stroke-like problems?
		19. High blood pressure?
		20. High cholesterol?
		21. Chronic cough or other breathing problems / asthma?
		22. Tuberculosis or exposure to tuberculosis?
GASTROINTESTINAL		
		23. Stomach or bowel problems?
		24. Liver problems (hepatitis or tumor, etc.)?
		25. Gallbladder problems?
GENITOURINARY		
		26. Bladder, urine leaks or kidney problems?
		27. Uterine fibroids?
		28. Ovarian cysts?
		29. Breast lump or nipple discharge?
		30. Vaginal discharge that itches, burns or has a bad odor?
		31. Endometriosis?
		32. Pain with sex? Other sex problems?
		33. Previous abnormal pap? When?
		34. Did your mother take DES when she was pregnant with you?
		35. Age of first vaginal intercourse _____
		36. History of sexually transmitted infection? Check type: <input type="checkbox"/> Chlamydia? <input type="checkbox"/> Gonorrhea? <input type="checkbox"/> Genital warts? <input type="checkbox"/> Herpes? <input type="checkbox"/> Syphilis? <input type="checkbox"/> PID <input type="checkbox"/> HIV/AIDS?
MUSCULOSKELETAL		
		37. <input type="checkbox"/> Arthritis? <input type="checkbox"/> Osteoporosis? <input type="checkbox"/> Other?
SKIN		
		38. <input type="checkbox"/> Acne or other skin problems? If yes, what? _____ <input type="checkbox"/> Tattoo? <input type="checkbox"/> Piercing? If yes, where? _____
NEUROLOGICAL		
		39. Migraine headaches / Aura (diagnosed by MD / NP / PA)?
		40. Seizures / epilepsy?
		41. Numbness in arms / legs (recurring)?
PSYCHOLOGICAL		
		42. Depression requiring treatment? Have you ever considered suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No Other psychological problems?

A. (cont'd) REVIEW OF SYSTEMS			
YES	NO	ENDOCRINE	
		43. Thyroid problems?	
		44. Diabetes?	
HEMATOLOGICAL/LYMPHATIC			
		45. Anemia (Low Iron)?	
		46. Sickle cell disease / trait?	
		47. Blood clotting disorder?	
ALLERGY			
		48. Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, to what? Type of reaction: _____	
IMMUNIZATION (Check the ones you have received)			
		49. <input type="checkbox"/> Diphtheria?	
		50. <input type="checkbox"/> Hepatitis A?	
		51. Hepatitis B <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?	
		52. Human Papillomavirus (HPV) <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?	
		53. <input type="checkbox"/> Measles/Mumps/Rubella (MMR)?	
		54. <input type="checkbox"/> Meningococcal?	
		55. <input type="checkbox"/> Pneumococcal?	
		56. <input type="checkbox"/> Tetanus?	
		57. <input type="checkbox"/> Varicella (chicken pox)?	
		58. Other	
B. HOSPITALIZATION AND SURGERIES			
Year	Reason		
C. ACCIDENTS AND INJURIES			
Year	Reason		
D. FAMILY HISTORY			
		Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Have your biological family (parents, brothers, sisters) had any of the following?	
YES	NO	Diagnosis	Relative
		Osteoporosis?	
		Diabetes?	
		Heart disease / heart attack / stroke before age 50?	
		High blood cholesterol?	
		Genetic problems?	
		Cancer? If yes, please specify _____	
		Blood clots?	
		Other?	
ADDITIONAL COMMENTS / EXPLANATIONS (by number)			

PLEASE COMPLETE OTHER SIDE

DATE \_\_\_\_\_

PT LABEL

E. PREGNANCY HISTORY <span style="float: right;">■ never pregnant</span>								
DELIVERED					ABORTION / MISCARRIAGE			
Mo.	Yr.	Vag.	C-Sec.	Birth Weight	Year	Weeks	Spont.	Induced

**F. CONTRACEPTIVE HISTORY**

Current birth control method? \_\_\_\_\_ How long used? \_\_\_\_\_

Any problems with this method?  Yes  No  
If yes, what? \_\_\_\_\_

What method do you want to use now? \_\_\_\_\_

Total number of children desired? \_\_\_\_\_

Are you planning a pregnancy in the NEXT year?  Yes  No  
If not, what would you do if you become pregnant within the NEXT year? \_\_\_\_\_

**WHICH OF THE FOLLOWING METHODS HAVE YOU USED IN THE PAST?**

METHOD	COMMENT/PROBLEM
<input type="checkbox"/> Abstinence?	
<input type="checkbox"/> Tubal? <input type="checkbox"/> Vasectomy? <input type="checkbox"/> Hysterectomy?	
<input type="checkbox"/> Birth Control Pill?	
<input type="checkbox"/> The Patch?	
<input type="checkbox"/> The Ring?	
Implant: <input type="checkbox"/> Norplant? <input type="checkbox"/> Implanon?	
<input type="checkbox"/> Depo-Provera (The Shot)?	
<input type="checkbox"/> IUD?	
<input type="checkbox"/> Condoms?	
<input type="checkbox"/> Diaphragm? <input type="checkbox"/> FemCap?	
<input type="checkbox"/> Lea's Shield?	
<input type="checkbox"/> Sponge? <input type="checkbox"/> Spermicide?	
<input type="checkbox"/> Rhythm?	
<input type="checkbox"/> NFP (Natural Family Planning)?	
<input type="checkbox"/> Withdrawal?	

**G. SOCIAL HISTORY**

Emotional?  Relationship problems?

Death of  Family member?  Friend?

Job loss?  Financial problems?

Problems in  Living arrangements?  School?

Legal problems?  Arrests?  Divorce?

Do you have any parental problems?

Are you physically abused?

Has anyone forced you to have sex?

Are you sexually abused?

Are you afraid of your  Partner?  Family member?

Who helps and supports you with your problems? \_\_\_\_\_

**H. MENSTRUAL HISTORY**

1. Age periods began? \_\_\_\_\_

2. Number of pads / tampons used on heaviest day? \_\_\_\_\_

3. Length of period? \_\_\_\_\_ (days) # of days between periods?

4. Are your periods usually regular?  Yes  No

5. Last period started on \_\_\_\_\_  
It seemed  Normal  Not normal

6. Do you experience, before or with periods,  Cramps?  
 Bloating?  Bowel problems?  Emotional changes?

7. Do you have vaginal bleeding after sex?  Yes  No

8. Do you have vaginal bleeding between menstrual periods?  
 Yes  No

**I. STI / HIV RISKS**

Number of sex partners in your life? MEN \_\_\_\_\_ WOMEN \_\_\_\_\_  
How many sex partners have you had during the past year?

Does your partner have sex with  men  women  both?  
Do you have (check all that apply)  vaginal  oral  anal sex?

**COMMENTS**

Have you ever used street drugs?  
If yes, when? \_\_\_\_\_

Have you received blood or blood products prior to 1978? \_\_\_\_\_

Were any of your partners:  a street drug user?  
 a Hemophiliac?  infected with HIV / AIDS?  
 MSM (men having sex with men)?

Have you ever shared needles?  
Examples: Injecting drugs, tattooing, piercing? \_\_\_\_\_

**STAFF COMMENTS (do not write anything in this space)**

\_\_\_\_\_

**To the best of my knowledge the information I have provided is correct and complete.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

**History reviewed:**

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_