

Planned Parenthood Association of the Mercer Area

Patient Registration Form

Regestación Para Paciente

Patient#/# del paciente _____

Please complete the following form. All the information is confidential.
Por favor complete la hoja seguida. Toda la información es confidencial.

First Name Primer Nombre _____	Last Name Apellido _____
Address Dirección _____	County Condado _____
City Ciudad _____	State Estado _____
SS# # de Seguro Social _____	Date of Birth Fecha de Nacimiento ____/____/____
	Zip Código Postal _____

House Hold Income Ingreso de la casa \$ _____	Yearly <input type="checkbox"/> Anual	Monthly <input type="checkbox"/> Mensual	Weekly <input type="checkbox"/> Semanal
Family Size Cuantos son en tu Familia _____	How many are children(s) Cuantos son niño(s) _____		

Home phone Numero de teléfono (____)____-____	Work phone Numero del trabajo (____)____-____
Emergency contact Phone number Numero de contacto de emergencia (____)____-____	Emergency contact Name Nombre del contacto de emergencia _____

Please check one of the four ways you want to receive you mail from us (PPAMA)
 Por favor marque una de las cuarto maneras que tu querré recibir correspondencia de nosotros (PPAMA)

Full return address <input type="checkbox"/> Dirección completa dé retorno	Street address ONLY <input type="checkbox"/> Solamente la dirección de la calle	NO return address <input type="checkbox"/> SIN dirección	NO mail <input type="checkbox"/> Ninguna respeta
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Please check one of the four ways you want to receive phone calls from us (PPAMA)
 Por favor marque una de las cuarto maneras que tu querré recibir llamas de nosotros (PPAMA)

Saying Planned Parenthood <input type="checkbox"/> Diciendo Planned Parenthood	Saying Doctor's Office <input type="checkbox"/> Diciendo oficina de doctor	Saying it's a friend <input type="checkbox"/> Diciendo que es una amiga	NO calls <input type="checkbox"/> Ninguna llamadas
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Please check all that apply
 Por favor marque todo que aplica

Sex	Female	Male								
Sexo -	<input type="checkbox"/> Femenino	<input type="checkbox"/> Masculino								
Race	American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or Pacific Islander	White					
Raza -	<input type="checkbox"/> Indio Americano o Nativo de Alaska	<input type="checkbox"/> Asiático	<input type="checkbox"/> Moreno o Americano Africano	<input type="checkbox"/> Nativo Hawaiano o Isleño Pacifico	<input type="checkbox"/> Blanco					
Hispanic	Yes - Hispanic or Latin	Not - Hispanic nor Latin	Unknown							
Hispano -	<input type="checkbox"/> Si - Hispano o Latino	<input type="checkbox"/> No - Hispano o Latino	<input type="checkbox"/> No sabes							
Marital Status	Divorced	Living together	Married	Separated	Single	Widowed				
Estado Marital -	<input type="checkbox"/> Divorciada	<input type="checkbox"/> Viven juntos	<input type="checkbox"/> Casada	<input type="checkbox"/> Separada	<input type="checkbox"/> Soltera	<input type="checkbox"/> Viuda				
Referral	Family o Friend	Hospital	Hot Line	Media	Other patient	Phone book				
Referido -	<input type="checkbox"/> Familia o Amiga	<input type="checkbox"/> Hospital	<input type="checkbox"/> Línea Abierta	<input type="checkbox"/> Medio de comunicación	<input type="checkbox"/> Otra paciente	<input type="checkbox"/> Libro de teléfono				
	Outreach	Private Doctor	Welfare							
	<input type="checkbox"/> Alcance	<input type="checkbox"/> Médico privado	<input type="checkbox"/> Welfare							
Language	English	Other					Interpreter Needed			
Idioma -	<input type="checkbox"/> Ingles	<input type="checkbox"/> Otro _____					<input type="checkbox"/> Necesito un Interprete			
Student	Yes	No	Highest grade f school you completed							
Estudiante -	<input type="checkbox"/> Si	<input type="checkbox"/> No	Grado mas alto que ha completado en la escuela _____							

Date: _____

Patient Label: _____

ABORTION SERVICES MEDICAL HISTORY

Planned Parenthood Association of the Mercer Area

Date of **Last Menstrual Period?** _____

Was this period normal? Yes No

Positive Pregnancy test? Clinic Home; Date _____

Have you ever had:

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Lung disease/TB/Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease/Heart Attack/Murmur/MVP |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol/triglycerides |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots in veins/lungs/varicose veins |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease/Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney/Bladder/Urinary problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Intestinal problems/Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Adrenal failure/insufficiency |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Vaginal infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Uterine fibroids/growth |
| <input type="checkbox"/> | <input type="checkbox"/> | Infection of Uterus or Tubes/PID |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast disease/Tumor/Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Pap Smear |
| <input type="checkbox"/> | <input type="checkbox"/> | STI/Chlamydia/Gonorrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines/Frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures/Epilepsy/Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia/Blood disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease/Trait |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV positive |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer Type _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous Surgeries/Hospitalizations |
| <input type="checkbox"/> | <input type="checkbox"/> | Any Chronic Illness/Medical Condition |

Do you have any **ALLERGIES** to the following? NONE

- Latex Novocain Lidocaine Iodine
 Aspirin Demerol Morphine Tetracycline
 Penicillin Other drug allergies, please list:

Have you ever had **ANESTHESIA** before? Yes No

If Yes, Local? General?

Any problems with anesthesia? Yes No

Are you taking any **MEDICATIONS** or **DRUGS**?
(include over-the-counter medication, herbals, vitamins)
Please list:

Are you adopted? YES NO

If YES, skip this section:

Have your Parents/Sister/Brother/or Grandparents ever had:

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer (Breast/Ovarian/Uterine/or Colon) |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol/triglycerides |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack/Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |

Social/Sexual History :

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke cigarettes? #/day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/Drug Use
If yes, type _____ |

Amount per day _____

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your partners shared needles to shoot/inject drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss problems related to rape or emotional/physical/sexual abuse? |
| <input type="checkbox"/> | <input type="checkbox"/> | At any time, has your partner hit, kicked or otherwise hurt or frightened you? |

Pregnancy History:

- _____ Total number of pregnancies (include this one)
 _____ Number of live births; Dates: _____
 _____ Number of miscarriages; Dates: _____
 _____ Number of abortions; Dates: _____
 _____ Number of C-sections; Dates: _____
 _____ Number of ectopic (tubal) pregnancies
 _____ Number of living children

Are you breastfeeding? Yes No

Did you have any complications during any pregnancy?

Yes No

If Yes, what? _____

The medical history I have completed is correct to the best of my knowledge.

PATIENT SIGNATURE _____

SIGNATURE/TITLE _____

FOR STAFF ONLY – DO NOT WRITE BELOW

Date: _____

Patient Label: _____

SURGICAL ABORTION COUNSELING

Planned Parenthood Association of the Mercer Area

- All pregnancy options reviewed and discussed with patient.
 - Patient is confident and clear about decision to have abortion Sad /angry / ambivalent but clear about decision
 - Client informed about what to expect emotionally and physically before, during, and after abortion including that a range of emotions is normal
 - Support System assessed Client Offered additional resources (i.e. Exhale #, Backline #, other)
 - Client @ potential Risk of poor coping due to : _____
 - Client referred to social worker/elsewhere for additional assessment/counseling Client decided to defer or delay the abortion.
 - Request for Medical Services, reviewed and discussed, signed by patient.
 - Request for Surgery or Special Procedure given, reviewed and discussed with patient, signed and a copy offered.
 - In-Clinic Abortion-Suction CIIC reviewed and discussed w/ patient .Patient signed and copy offered.
(Questions concerning risks of surgical procedure answered.)
 - Patient contact information reviewed for accuracy.
Rho (D) Immune Globulin information form given, reviewed and discussed YES NO Not Applicable
 - Vital signs taken and documented below.
 - Current medications and allergies documented below. Pregnancy history documented below.
 - Birth Control Methods reviewed and discussed.
Method Selected: _____ Informed Consent given and signed.
 - Local anesthetic discussed.
Previous experience with lidocaine? YES NO Allergic to lidocaine? YES NO
 - GC/Chlamydia testing offered. Patient : Accepted Declined
 - Patient's method of transportation home _____
 - Follow-up appointment scheduled for _____
 - Payment: Amount collected documented on super bill OR insurance copied and attached to super bill and lab form.
- Staff Notes: _____

Date _____

Signature, Title _____

PHYSICAL EXAMINATION

EXAM DEFFERED

Hgb _____ Rh Status _____ Ht. _____ Wt. _____ B/P _____ Pulse _____ Temp. _____

G _____ P _____ A _____ M _____ C-sec _____ Ectopic _____

Allergies _____

Current Medications _____

General _____
Heart Normal _____

External _____
Genitalia Normal _____

Lungs Normal _____

Vagina Normal _____

Abdomen Normal _____

Cervix Normal _____

Breast Normal _____

Adnexa Normal _____

Uterus Size: _____

Position Mid Anteverted Retroverted

Pap Obtained Today Yes No

Osmotic Dilators(s) used Yes No

Misoprostol used buccal/oral/vaginal Yes No

Comments: _____

Date _____

MD Signature _____