

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

FAMILY PLANNING ANNUAL HISTORY

Planned Parenthood Association of the Mercer Area

The reason for your visit today _____

Do you have any concerns or problems you wish to talk about today? Yes No

If yes, please explain _____

Do you have any **ALLERGIES**? No known allergies

Allergy to:

 Medication Latex Metals Anesthesia Other

Please specify and include type of reaction: _____

MENSTRUAL HISTORY

Date your last period began? _____

How often do you get a period? _____

Number of days your periods last? _____

Number of pads/tampons used on heaviest day? _____

Yes No

- Was your last period normal?
If no, explain _____
- Do you get severe cramps with your period?
- Do you miss periods?
- Do you bleed between periods?
- Are you concerned you may be pregnant NOW?
- Do you douche?

SEXUAL HISTORY

Your answers to the following questions will help us assess your risk for cervical cancer and sexually transmitted infections (STI's). All information is confidential.

 Never had any sex (skip this section)Types of sexual activity: vaginal oral anal

Are your current and past partners:

 male female both**Yes No**

- Have you had more than one, or a new sexual partner in the past year?
- Do you or your partner use condoms?
If yes, Every time Not every time
- Do you want to be tested for sexually transmitted infections or HIV today?
- Do you have questions or concerns about sex that you wish to talk about today?

PAST MEDICAL HISTORY

Have you been diagnosed with any new health problems since your last medical history dated ____ / ____ / ____?
(Include any NEW pregnancies.)

 YES NO

List all medication you are currently taking or use often (include over-the-counter medicines, vitamins, birth control, and any herbal supplements)

FAMILY HISTORY

Have any of your immediate family members been diagnosed with a new health problem since your last visit?

 YES NO**SOCIAL AND HEALTH RISK HISTORY****Yes No**

- Do you smoke cigarettes or cigars?
If yes, how many per day? _____
- Do you drink alcohol?
If yes, how often? _____
How many drinks? _____
- Do you use street drugs?
If yes, what and how often? _____
- Have you or any of your sexual partners ever used IV (injectable) drugs?
- Do you have exposure to blood or blood products at work?
- Would you like to discuss anything about sexual assault, rape, or abuse (includes: physical, emotional, sexual) today?
- Are you currently in a relationship where you have been hurt, threatened, or do not feel safe?
- Do you use seatbelts?
- Do you check your breasts regularly?
If yes, how often? _____
- Do you exercise?
If yes, type of exercise and how often? _____
- Do you have concerns about your weight or eating habits?
If yes, explain _____

CONTRACEPTIVE HISTORY**Yes No**

- Do you use birth control currently?
If yes, what type? _____
- Do you have problems with your birth control?
If yes, explain _____
- Have you had sex without using any kind of birth control since your last period?
If yes, when? _____

To the best of my knowledge, this information is correct.

Patient Signature _____ Date _____

Clinician Review _____ Date _____