

# 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 _____			

# Planned Parenthood Association of the Mercer Area

## MEDICAL HISTORY FORM FOR ECPS WITH A DEFERRED EXAM

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

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Brief Medical History

Have you ever had:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Stroke?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Clots?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart attack or chest pains?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver tumor or disease?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High cholesterol?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bad headaches?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast cancer or lumps in your breast? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Serious illness?                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are you over 35? Yes No

Do you smoke? Yes No

Has a parent, brother or sister had a heart attack before age 55? Yes No

Current birth control method \_\_\_\_\_

Have you had sex without birth control since your last period? Yes No

If yes.....Date \_\_\_\_\_ Time \_\_\_\_\_

Did anyone force you to have sex? Yes No

Date of last menstrual period \_\_\_\_\_ Was it a normal period? Yes No

Have your periods been abnormal or irregular lately? Yes No

If yes, describe \_\_\_\_\_

Do you think you are pregnant now? Yes No

Are you nursing a baby? Yes No

If pregnant before, please list dates of:

Live Births \_\_\_\_\_ Abortions \_\_\_\_\_ Ectopics \_\_\_\_\_ Miscarriages \_\_\_\_\_

Other \_\_\_\_\_

### General Health Questions

When was your last physical exam? \_\_\_\_\_ Was it normal? Yes No

When was your last Pap smear? \_\_\_\_\_ Was it normal? Yes No

When was your last breast exam? \_\_\_\_\_ Was it normal? Yes No

When was your last mammogram? \_\_\_\_\_ Was it normal? Yes No

Do you have any abnormal or unusual vaginal discharge? Yes No

Have you had a change of sexual partners in the last 6 months? Yes No

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR STAFF ONLY – DO NOT WRITE BELOW THIS LINE**

Name: \_\_\_\_\_  
 Chart #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

Assessment

Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

If Indicated, laboratory test result: Type of Pregnancy Test: \_\_\_\_\_ Result: \_\_\_\_\_

GC/Chlamydia Testing done: Yes No Result: \_\_\_\_\_

<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient stated that she wants Emergency Contraceptive Pills (ECPs).
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient was told about available options to ECPs. Information on contraceptive methods given. Patient was counseled per PP protocol regarding ECP Patient was given the Client Information for Informed Consent (CIIC): ECPs., with instructions for use completed on form. Complete the Request for Medical Services Method Specific form, signature obtained Patient appropriate candidate for ECPs ECP given
Notes:	
Staff Signature: _____ Date: _____	
<b>ECP ORDER:</b> <input type="checkbox"/> Plan B #2 Tabs <input type="checkbox"/> (2) tabs PO now <input type="checkbox"/> Prophylactic PRN w/in 120 hrs unprotected IC Refill x_____ Rx given <input type="checkbox"/> <input type="checkbox"/> Plan B #2 Tabs <input type="checkbox"/> (1) tab PO now (1) tab in 12 hours <input type="checkbox"/> Prophylactic PRN w/in 120 hrs unprotected IC Refill x_____ Rx given <input type="checkbox"/> <input type="checkbox"/> Other ( <i>directions and prophylaxis regime to be written here.</i> )	
_____ Clinician Signature	_____ Date

New Patient Packet of Information given

Client to return: \_\_\_\_\_

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