

# 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 _____	Zip Código Postal _____
State Estado _____	
SS# # de Seguro Social _____	Date of Birth Fecha de Nacimiento ____/____/____

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 corresponda 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
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
	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 INITIAL HISTORY

Planned Parenthood Association of the Mercer Area

Welcome to Planned Parenthood Association of the Mercer Area. This information will help us determine your health needs. All information is confidential.

The reason for your visit today \_\_\_\_\_

Do you have any ALLERGIES? [ ] No known allergies
Allergy to:

[ ] Medication [ ] Latex [ ] Metals [ ] Anesthesia [ ] Other
Please specify and include type of reaction:

MENSTRUAL HISTORY

Your age when periods started? \_\_\_\_\_

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)

Your age when you first had sex: \_\_\_\_\_

Types of sexual activity: [ ] vaginal [ ] oral [ ] anal

Are your current and past partners:

[ ] male [ ] female [ ] both

Yes No

- [ ] [ ] Do you have a current sexual partner?
[ ] [ ] 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 have concerns about a sexually transmitted infection or HIV?
[ ] [ ] 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?
[ ] [ ] Have any sexual partners been bisexual?

Date of LAST PAP SMEAR: \_\_\_\_\_

[ ] Never had previous pap smear

Date of LAST MAMMOGRAM: \_\_\_\_\_

[ ] Never had previous mammogram

PREGNANCY HISTORY

[ ] I have never been pregnant (skip this section)

How many times have you been pregnant? \_\_\_\_\_

Dates of Live births: \_\_\_\_\_

Dates of Miscarriages: \_\_\_\_\_

Dates of Still births: \_\_\_\_\_

Dates of Abortions: \_\_\_\_\_

Dates of Premature births: \_\_\_\_\_

Dates of Tubal pregnancies: \_\_\_\_\_

Dates of Caesarean births: \_\_\_\_\_

Number of Living Children: \_\_\_\_\_

During any pregnancy did you have:

- [ ] Diabetes [ ] High blood pressure
[ ] A premature baby [ ] A child with a birth defect

Are you currently breastfeeding? [ ] Yes [ ] No

CONTRACEPTIVE HISTORY

Check all of the birth control methods you have used:

- [ ] Abstinence [ ] Condoms [ ] Pills
[ ] "Depo"/"shot" [ ] Patch [ ] Nuvaring
[ ] Diaphragm/cap [ ] IUD [ ] Withdraw
[ ] Spermicide/foam [ ] Vasectomy [ ] Hysterectomy
[ ] Sterilization/"tubal" [ ] Norplant [ ] Lunelle
[ ] Rhythm/natural family planning

Yes No

- [ ] [ ] Do you use birth control now?
If yes, what method do you use? \_\_\_\_\_
[ ] [ ] Have you had problems with birth control?
If yes, explain \_\_\_\_\_
[ ] [ ] Do you want a birth control method today?
If yes, which method? \_\_\_\_\_
[ ] [ ] Do you plan to have children?
If yes, when? \_\_\_\_\_
[ ] [ ] Have you had sex without using any kind of birth control since your last period?
If yes, when? \_\_\_\_\_

**PAST MEDICAL AND SURGICAL HISTORY**

**Yes No**

- Are you currently under medical care for a serious illness or chronic medical condition?  
If yes, describe \_\_\_\_\_
- Have you ever had surgery?  
If yes, what kind? \_\_\_\_\_
- Have you ever been admitted to a hospital for an overnight or longer stay? If yes, what was the reason? \_\_\_\_\_
- Have you had any transfusions of blood or blood products before 1991?
- Do you have another health care provider?  
If yes, where? \_\_\_\_\_

Have you been immunized (had vaccines or "shots") for:

**Yes No Don't Know**

- Rubella/German measles (in MMR)
- Hepatitis B

**In the past have you had, or do you now have:**

**Yes No**

- Asthma/lung disease
- Heart disease/heart attack
- High blood pressure
- High cholesterol
- Anemia/other blood disorder
- Sickle cell disease or trait
- Thalassemia disease or trait
- Stroke/mini stroke
- Doctor diagnosed migraine
- Other severe headaches
- Other neurologic problem
- Lupus or arthritis
- Depression
- Other mental health problem
- Obesity/bulimia/anorexia
- Stomach or bowel disease
- Liver or gallbladder disease
- Thyroid disease
- Kidney disease
- Diabetes
- Urine or Kidney infections
- Cancer; If yes, kind \_\_\_\_\_
- Breast disease
- Uterine fibroids and/or ovarian cyst
- Endometriosis
- Abnormal Pap smear: If yes, when? \_\_\_\_\_  
Any treatment? \_\_\_\_\_
- Sexually transmitted infection

If yes, please specify:  Chlamydia  Gonorrhea  Herpes

Syphilis  HIV  Trichomoniasis  Hepatitis B carrier

Genital warts/HPV  Other, \_\_\_\_\_

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

**FAMILY HISTORY**

I'm adopted (skip this section)

Has anyone in your **immediate** family ever had:

If yes, please indicate relationship as (M) mother; (F) father; (B) brother; (S) sister; (C) child.

- Diabetes \_\_\_\_\_  High blood pressure \_\_\_\_\_
- Stroke \_\_\_\_\_  High cholesterol \_\_\_\_\_
- Heart Attack \_\_\_\_\_  Ovarian Cancer \_\_\_\_\_
- Breast Cancer \_\_\_\_\_  Uterine Cancer \_\_\_\_\_
- Colon Cancer \_\_\_\_\_
- Osteoporosis (thinning of bones) \_\_\_\_\_

If you were born before 1971, did your mother take DES hormone when she was pregnant with you?

- Yes  No  Don't Know  Born after 1971

**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 per day? \_\_\_\_\_
- Do you use street drugs?  
If yes, what and how often? \_\_\_\_\_
- Have you ever had a problem with alcohol or drugs?
- 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 \_\_\_\_\_

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

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Clinician Review** \_\_\_\_\_ **Date** \_\_\_\_\_

