

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

House Hold Income \_\_\_\_\_ Yearly \_\_\_\_\_ Monthly \_\_\_\_\_ Weekly \_\_\_\_\_  
Ingreso de la casa \$ \_\_\_\_\_  Anual  Mensual  Semanal

Family Size \_\_\_\_\_ How many are children(s) \_\_\_\_\_  
Cuantos son en tu Familia \_\_\_\_\_ Cuantos son niño(s) \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Numero de teléfono (\_\_\_\_)\_\_\_\_-\_\_\_\_ Numero del trabajo (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Emergency contact Phone number \_\_\_\_\_ Emergency contact Name \_\_\_\_\_  
Numero de contacto de emergencia (\_\_\_\_)\_\_\_\_-\_\_\_\_ 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 \_\_\_\_\_ Street address ONLY \_\_\_\_\_ NO return address \_\_\_\_\_ NO mail \_\_\_\_\_  
 Dirección completa dé retorno  Solamente la dirección de la calle  SIN dirección  Ninguna respeta

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

Saying Planned Parenthood \_\_\_\_\_ Saying Doctor's Office \_\_\_\_\_ Saying it's a friend \_\_\_\_\_ NO calls \_\_\_\_\_  
 Diciendo Planned Parenthood  Diciendo oficina de doctor  Diciendo que es una amiga  Ninguna llamadas

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

## EVALUACION DE EMBARAZO - FORMA PARA EL EXPEDIENTE MEDICO

### PREGNANCY EVALUATION MEDICAL HISTORY FORM

Fecha/Date: \_\_\_\_\_

Nombre/Name: \_\_\_\_\_

Numero del expediente/Chart #: \_\_\_\_\_

Fecha de nacimiento/Date of Birth: \_\_\_\_\_

#### Breve Historia Medica/Brief Medical History

- ¿Cuál es la fecha del primer día de su última periodo que le haya bajado normal?** \_\_\_\_\_  
When was the first day of your last normal menstrual period (date)? \_\_\_\_\_
  - El periodo fue/This period was:**  **a tiempo/on time**  **se adelanto/early**  **se retraso/late**
  - El flujo de sangre fue/The amount of bleeding was:**  **normal/normal**  **liviano/lighter**  **fuerte/heavier**
  - Sus ciclos mensuales/Are your cycles:**  **regulares/regular**  **irregulares/irregular**
- Por favor marque los síntomas que usted ha tenido recientemente:**  
Please check off any symptoms that you have noticed recently:  
 **Náusea/Vomiting**  **Fatiga/Excess fatigue**  **Inflamación del abdomen/Swelling in abdomen**  
 **Orina con mas frecuencia/Increased Urination**  **Fiebre o escalofrios/Fever or chills**  
 **Sensibilidad/hinchazón de los senos/Breast tenderness/swelling**  
 **Dolor abdominal severo o persistente/Severe or persistent abdominal pain**  
 **Dolor en los hombros/Shoulder pain**  \_\_\_\_\_ Spotting or Bleeding
- ¿Ha tenido relaciones sexuales sin protección desde su último periodo?**  **No**  **Si/yes** **Cuando:** \_\_\_\_\_  
Have you had unprotected sex since your last period? \_\_\_\_\_ If yes, last date: \_\_\_\_\_
- Esta usando algún método de anticonceptivo.**  **No**  **Si/yes** **Cual:** \_\_\_\_\_  
Are you currently using a method of birth control \_\_\_\_\_ If yes, what type: \_\_\_\_\_
- Esta planiando un embarazo actualmente.**  **No**  **Si/yes**  
Were you planning a pregnancy at this time?
- Anteriormente ha tenido otros embarazos/** Have you been pregnant before?  **No**  **Si/yes**  
**Si ha estado embarazada por favor indique la(s) fecha(s):** If yes, please indicate the dates of:  
**Partos vivos/Live births** \_\_\_\_\_ **Abortos Naturales/Miscarriages** \_\_\_\_\_  
**Abortos provocados/Abortions** \_\_\_\_\_ **Embarazos ectópicos/Tubal pregnancies** \_\_\_\_\_
- Por favor mencione los problemas médicos que tiene o ha tenido:** \_\_\_\_\_  
Please list current or continuing medical problems: \_\_\_\_\_
- Ha tenido: Gonorrea, clamidia, infección en el útero/tubos (PID), o alguna infección después de un aborto o parto.**  
Have you ever had: gonorrhea or Chlamydia, an infection in your uterus/tubes (PID), or an infection after an abortion or delivery?  
 **No**  **Si/yes** **Si, por favor especifique** \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_
- Mencione los medicamentos o vitaminas que esta tomando,** \_\_\_\_\_  
Please list any medications or vitamins you are currently using \_\_\_\_\_
- Estas usando algún tipo de drogas.**  **No**  **Si** **Cuando:** \_\_\_\_\_  
Are you taking any street drugs?  **No**  **Yes** If yes, which ones? \_\_\_\_\_
- Ha tomado algún medicamentos o has usado drogas en las últimas 24 horas.**  **No**  **Si** **Cuando:** \_\_\_\_\_  
Have you taken any medicines or drugs in the last 24 hours?  **No**  **Yes** If yes, which ones? \_\_\_\_\_

Firma del Paciente/Patient Signature: \_\_\_\_\_

#### Lab Notes

Date: \_\_\_\_\_ Type of Test: \_\_\_\_\_

Result: \_\_\_\_\_ Technician Signature and Title: \_\_\_\_\_

Nombre/Name: \_\_\_\_\_

Numero del paciente/Chart #: \_\_\_\_\_

Fecha de nacimiento/Date of Birth: \_\_\_\_\_

**Counseling Notes:**

Folic Acid Information given  Folic Acid Given  400mg or  800mg or  RX

Patient offered Urine GC/Chlamydia testing  accepted  declined

Trust In Yourself Information Sheet Given to patient

**Positive Test**

Number of Weeks since LMP: \_\_\_\_\_

Continuing Pregnancy

\_\_\_\_\_ Folic Acid Information Provided

\_\_\_\_\_ Patient given Folic Acid  400mg or  800mg or  RX

\_\_\_\_\_ Patient reminded of need for pelvic exam within 30 days

\_\_\_\_\_ Explained risk of drugs, alcohol, smoking, and X-rays

\_\_\_\_\_ Patient offered referral for prenatal care elsewhere. Referred to \_\_\_\_\_

\_\_\_\_\_ Patient undecided about where to access care. Three referrals provided:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

\_\_\_\_\_ Patient interested in adoption. Adoption information and referrals provided.

Abortion

\_\_\_\_\_ Patient reminded of the need for pelvic confirmation within 7 days

\_\_\_\_\_ Surgical and Medical Abortion options explained to patient

\_\_\_\_\_ Patient requested referral for termination of pregnancy. Referred to \_\_\_\_\_

\_\_\_\_\_ Patient undecided about where to access care. Three referrals provided:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**How is the client feeling about her decision?**

\_\_\_\_\_ Confident and clear about decision to have the abortion

\_\_\_\_\_ Sad / angry / afraid / ambivalent feelings but clear about decision

\_\_\_\_\_ Support System assessed

\_\_\_\_\_ Referred for additional Counseling.

Undecided

\_\_\_\_\_ Patient referred for an additional Options Counseling session. Referred to: \_\_\_\_\_

\_\_\_\_\_ Patient reminded the importance of making a decision within the appropriate time frame

\_\_\_\_\_ Patient provided with PPAMA phone number and counselor name.

\_\_\_\_\_ Patient support system assessed

\_\_\_\_\_ Folic Acid Information Provided

\*If patient is under <18 years old, will they need assistance disclosing this pregnancy to a parent/guardian?

No  Yes

**Negative Test**

Desires Pregnancy

\_\_\_\_\_ Natural Family Planning information provided

\_\_\_\_\_ Folic Acid Information Provided

Does Not Desire Pregnancy

\_\_\_\_\_ Contraceptive information provided and discussed with patient

\_\_\_\_\_ STI information provided and discussed , Urine GC/Chlamydia Testing offered  Accepted  Declined

\_\_\_\_\_ Patient explained the need for a repeat test in 7-10 days if normal menses does not ensue

\_\_\_\_\_ Patient offered a family planning visit if not currently using birth control

\_\_\_\_\_ Patient offered condoms and spermicide

\_\_\_\_\_ Patient selected other provider from whom she plans to seek follow-up care

Signature and Title: \_\_\_\_\_