

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 \$ _____	<input type="checkbox"/> Anual	<input type="checkbox"/> Mensual	<input type="checkbox"/> 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 cuarto 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 _____			

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PREGNANCY EVALUATION MEDICAL HISTORY FORM

Date: _____

Name: _____

Chart #: _____

Date of Birth: _____

Brief Medical History

1. When was the first day of your last normal menstrual period (date)? _____
 - a. This period was: on time early late
 - b. The amount of bleeding was: normal lighter heavier
 - c. Are your cycles: regular irregular
2. Please check off any symptoms that you have noticed recently:
 Nausea/Vomiting Excess fatigue Swelling in abdomen Increased Urination Fever or chills
 Breast tenderness/swelling Severe or persistent abdominal pain Shoulder pain Spotting or Bleeding
3. Have you had unprotected sex since your last period? No Yes If yes, last date: _____
4. Are you currently using a method of birth control? No Yes If yes, what type: _____
5. Were you planning a pregnancy at this time? No Yes
6. Have you been pregnant before? No Yes If yes, please indicate the dates of:
Live births _____ Miscarriages _____
Abortions _____ Tubal pregnancies _____
7. Please list current or continuing medical problems: _____
8. Have you ever had: gonorrhea or Chlamydia, an infection in your uterus/tubes (PID), or an infection after an abortion or delivery? No Yes If yes, please explain:

9. Please list any medications or vitamins you are currently using _____.
10. Are you taking any street drugs? No Yes If yes, which ones? _____
11. Have you taken any medicines or drugs in the last 24 hours? No Yes If yes, which ones?

Patient Signature: _____

Lab Notes

Date: _____ Type of Test: _____

Result: _____ Technician Signature and Title: _____

Name: _____

Chart #: _____

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. _____
- _____ Birth Control and STI Information provided

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 , offered Urine GC/Chlamydia testing 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: _____