

PLANNED PARENTHOOD OF MIDDLE & EAST TENNESSEE  
Confidential Contact and Demographic Information

Please Print Clearly

Today's Date: \_\_\_\_\_

I understand that PPMET must be able to contact me by phone and mail to give me important information. I request that PPMET use the address and phone # below:

\_\_\_\_\_  
Social Security Number      Birth Date      Age

\_\_\_\_\_  
Last Name      First Name      MI

\_\_\_\_\_  
Street Address      Apt

\_\_\_\_\_  
City      State      ZIP

\_\_\_\_\_  
County

\_\_\_\_\_  
Phone      Other Phone

Alternate Address: (complete this section *only* if we can not contact you at the address listed above)

\_\_\_\_\_  
Street Address      Apt

\_\_\_\_\_  
City      State      ZIP

\_\_\_\_\_  
County

**Emergency Contact(s):**

In case of emergency, if PPMET can not get in touch with me, this person will get me a message:

\_\_\_\_\_  
Name      Phone Number

In addition, this person has permission to pick up birth control pills for me, after showing identification:

\_\_\_\_\_  
Name      Phone Number

**Pregnancy History:**

Number of Pregnancies (including current): \_\_\_\_\_

Number of Live Births: \_\_\_\_\_

Now Living: \_\_\_\_\_

Now Dead: \_\_\_\_\_

Miscarriages (Spontaneous): \_\_\_\_\_

Abortions (Induced): \_\_\_\_\_

**Marital Status:**

Single  Partnered/Married  Separated  Divorced  Widowed

**Sex:**  Female  Male  Transgender

**Race/Ethnicity:**

White  Black  Native American  Asian

Multiracial  Other

Are you of Hispanic Descent?  Yes  No

**Education:**

Highest grade in school that you have completed? \_\_\_\_\_

Are you currently a student?  No  Yes

If yes, where? \_\_\_\_\_

Full-time

Part-time

**Insurance:**

Do you have Health Insurance?  Yes  No

If yes, Name of Insurer: \_\_\_\_\_

Place of Work: \_\_\_\_\_

**Request for Medical Services and Acknowledgement of Receipt of Notice of Health Information Privacy Practices**

I-B-2a

Revised June 2007

Reviewed September 2011

**Planned Parenthood of Middle & East Tennessee**

Knoxville Health Center, 710 N. Cherry Street, Knoxville, TN 37914 865.694.7155  
Nashville Health Center, 412 Dr. D. B. Todd Blvd, Nashville, TN 37203 615.321.7216

**REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE \_\_\_\_\_ PATIENT # \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I have been given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in PPMET's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

**Request for Medical Services and Acknowledgement of Receipt of Notice of Health Information Privacy Practices**

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I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

**I hereby acknowledge** receipt of PPMET's notice of health information privacy practices.

Signature of patient \_\_\_\_\_

Date \_\_\_\_\_

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness \_\_\_\_\_

Date \_\_\_\_\_

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW
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Signature of any other person consenting \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Date \_\_\_\_\_

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Signature of witness \_\_\_\_\_

Date \_\_\_\_\_

INITIAL HISTORY — COMPREHENSIVE

CLIENT LABEL

Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_ Client ID #: \_\_\_\_\_ D.O.B.: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Yes	No		Yes	No	
		1. Do you take any medicine (prescription, over the counter, herbs, vitamins)? If yes, what?			35. Have you ever been in the hospital overnight?
		2. Are you allergic to any drugs, medicines, or latex? If yes, what?			36. Have you ever had surgery?
		3. Are you using a birth control method? If yes, what? Any problems?			37. Are you planning a surgery that will keep you in bed for a long time?
		4. Do you want to change your birth control?			38. Have you ever used street drugs? If yes, what kind:
		5. Do you want to get pregnant in the future? If yes, <input type="checkbox"/> In the next year <input type="checkbox"/> not for awhile <input type="checkbox"/> don't know			39. Do you use street drugs now? If yes, what kind:
					40. Have you ever smoked? If yes, how long:
					41. Do you smoke now? If yes: How many packs per day? How many years?
					42. Do you drink alcohol? If yes: Drinks/day: Drinks/wk: Type of drink:
					43. Any recent life changes or stresses? If yes, what kind:
					44. Are you worried about your weight or eating habits? If yes, why:
					45. Do you eat a healthy diet?
					46. Do you take calcium?
					47. Do you take vitamin D?
					48. Do you take folic acid?
					49. Do you get regular exercise? If yes, what?
					50. Do you use a seat belt?
					51. Are there any health hazards at home/work/play? If yes, what:
					52. Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?
					53. Does your partner refuse to use condoms when you ask?
					54. Has your partner ever tried to force or pressure you to become pregnant when you didn't want to be?
					55. Are you afraid your partner will hurt you if you tell him you have an STI and he needs to be treated?
					56. Have you ever been physically or emotionally abused by your partner or someone important to you?
					57. Have you been hit, slapped, kicked or otherwise physically hurt by someone in the past year or, if you're pregnant, since you've been pregnant?
					58. Has anyone forced you to have sex in the past year?
					59. Are you afraid of your partner?
		<b>Check the immunizations you have received.</b>			
		33. <input type="checkbox"/> Chicken pox <input type="checkbox"/> HPV — shot 1, shot 2, shot 3 <input type="checkbox"/> Flu <input type="checkbox"/> Measles/mumps/rubella (MMR) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tetanus/diphtheria (Td) <input type="checkbox"/> Hepatitis B — shot 1, shot 2, shot 3 <input type="checkbox"/> Other			
		34. Age at first period: _____ Number of days between periods: _____ Length of period: _____ Do you think your periods are heavy? <input type="checkbox"/> yes <input type="checkbox"/> no Any recent changes in your periods? <input type="checkbox"/> yes <input type="checkbox"/> no			

60. Have you ever been pregnant?  yes  no  
 If yes, how many times: \_\_\_\_\_  
 Number of abortions or miscarriages: \_\_\_\_\_  
 Number of normal vaginal deliveries: \_\_\_\_\_  
 Number of c/sections: \_\_\_\_\_

61. Have you ever had a complication with a pregnancy or birth?  yes  no If yes, what?  Diabetes  High Blood Pressure  Preeclampsia/Toxemia  Premature Baby  Depression after giving birth  Other

62. Are you having sex?  yes  no If yes, do you have sex with:  men  women  both  oral  vaginal  anal

63. How many sex partners have you had within the last 12 months? \_\_\_\_\_

65. Any new sex partners within the past three months?  yes  no

66. Do you use condoms?  always  sometimes  never

67. Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still having sex with you?  yes  no

68. Do you or your partner(s) use IV drugs?  yes  no

69. Have you ever had an STI?  yes  no  
 If yes, check all that apply:  Chlamydia  Gonorrhea (GC)  Genital Warts  Hepatitis B  Hepatitis C  Herpes  HIV/AIDS  Molluscum  Syphilis  Trichomoniasis (trich)

70. Are you adopted?  yes  no  
 Do you know your family history?  yes  no

71. Have any of your relatives had any of the problems listed below? If yes, please list.

Yes	No	Diagnosis	Relative(s)	How old?
		Diabetes		
		Stroke		
		Heart Disease		
		Blood clots in lungs or legs		
		High blood pressure		
		High cholesterol		
		Hepatitis		
		HIV/AIDS		
		TB		
		Birth Defect		
		Alcohol or drug problems		
		Cancer		
		Mental illness/ depression		
		Alzheimer's (dementia)		
		Other		

Yes	No	Have you recently had any of the following?
		72. Lost weight
		73. Gained weight
		74. Felt very, very tired
		75. Gotten shorter

Yes	No	Do you have any of the following now?
		76. Fevers
		77. Trouble sleeping
		78. Frequent headaches
		79. Vision changes / Glasses/Contacts
		80. Earaches / Ringing in ears / Hearing problems
		81. Sinus / sore throat / mouth / teeth problems
		82. Chest pain or pressure
		83. Fast or irregular heartbeat
		84. Trouble breathing with light exercise / when resting
		85. Painful breathing /wheezing / spitting up blood / cough
		86. Problems with bowel movement / gas / nausea /vomiting
		87. Problems with urination
		88. Painful periods
		89. Painful sex
		90. Abnormal vaginal discharge
		91. Muscle weakness / muscle or joint pain
		92. Rashes / sores /acne / changes to skin moles
		93. Breast pain / nipple discharge / breast lump
		94. Dizziness
		95. Seizures / numbness
		96. Depression /frequent crying / anxiety
		97. Hair loss
		98. Feeling very hot or cold / hot flashes
		99. More thirst than usual
		100. Frequent bruises / Cuts that don't stop bleeding
		101. Swollen glands
		102. Allergies. If yes, what kind? Reactions?

**Staff Comments (do no write anything in this space)**

**I filled out the form as best I could and believe the information is correct.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

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

**Reviewed and updated history with client.**

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

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

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