Planned Parenthood®
of Nassau County, Inc.

Name ______________________________________ Age _____ Today's Date __________________

Address ______________________________________ Telephone # __________________________
Can we say Planned Parenthood? Yes /No

MEDICAL VISIT

First Day of Last Period ___/___/___ Was this a Normal Period? Yes ___ No ___

Reason for Visit:

_____________ Symptoms in Self
_____________ Routine Screening Exam
_____________ Contact to ____________ (STD)
_____________ Referral From _______________
_____________ Other: _____________________

Allergies: _____________________________________

Medicine/drug use past 30 days
Yes _____ No _____
Medicine/Drug ______________________________________
For ______________________________________
Last Dose ______________________________________

Sexual History:

Total # of partners in lifetime ______________
# of partners in past 3 months _____________
male ___________ # female ____________
Date of last sexual contact: _______________
Sites of sexual contact:
( ) vaginal ( ) oral ( ) anal
Does your partner have any symptoms? Yes / No
Explain if yes: _______________________________
____
____

Pregnancy History: (only answer if you have never been here before)

Have you ever been pregnant? Yes / No
Date(s) of Pregnancies_____________________
Total Pregnancies _________________________
Number of:
______ abortions _____ ectopic pregnancies
______ miscarriages _____ live births
______ caesarians _____ premature births

Symptoms:	Where	How Long?
_____ Discharge	_______	_________
_____ Burning when urinating	_______	_________
_____ Lesion (sore)	_______	_________
_____ Rash	_______	_________
_____ Itch	_______	_________
_____ Pain	_______	_________
_____ Warts (Bumps)	_______	_________
_____ Chills/Fever	_______	_________
_____ Unexplained weight loss	_______	_________
_____ Swollen glands	_______	_________
_____ Breast Lump	_______	_________
_____ Breast Pain	_______	_________
_____ Nipple Discharge	_______	_________
If yes, what color?	____________________	
_____ Other:	____________________	

Menstrual History:

_____________ age period started
Periods are:
_____ regular _____ light
_____ irregular _____ moderate
_____ painful _____ heavy
Periods come every __________ days
They last ______________ days
Bleeding between periods? Yes / No
During intercourse, do you have pain? Yes / No Bleeding Y / N
Last Pap Smear __________________ (date)
Have you ever had an abnormal pap smear? Yes / No
If yes, what was the result? ___________________________
Have you ever had a colposcopy/Cryotherapy/LEEP? Y/N
If yes, when ____________________ (date)

Contraceptive History:

Do you use birth control now? Yes / No
If yes, what method? _________________________________
Does your partner use condoms? Yes / No /Not Applicable
Have you had sex without using birth control since your last period? Yes / No
Do you think you might be pregnant now? Yes / No

STI/Infection History:

	When?
_____ Gonorrhea	____________
_____ Syphilis	____________
_____ Chlamydia	____________
_____ Herpes	____________
_____ Warts/HPV	____________
_____ PID	____________
_____ UTI (bladder infection)	____________
Vaginal Infections	
_____ Trich	____________
_____ Bacterial Vaginosis	____________
_____ Yeast	____________

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Patient Label

Purpose of Visit: ____________
Allergies: __________________
LMP ____/____/ ____

HGB: ____________

Urine: _____Protein _____Glucose
_____Leukocytes _____ Nitrites

□ PAP ________________________
□ GC ___________CHL__________
□ Pregnancy Test _______________
□ Wet Mount ___________________
□ VDRL _______________________
□ Herpes Select I □ II □ Both □
□ Culture: □ Herpes □ Urine □ Vaginal

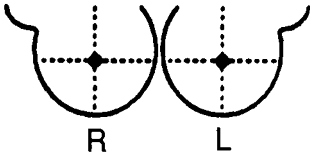
STD Risks: __________________
□ Multiple Partners
□ New Partner since Last Year

FOR STAFF USE ONLY

Skin: ( ) Normal ( ) Abnormal
( ) Lesion ( ) Rash ( ) Alopecia

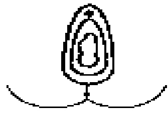
Lymph Nodes: ( ) Not Palpable ( ) Palpable
( ) Cervical ( ) Axillary ( ) Inguinal

Breasts:



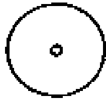
Nipple Discharge Y / N
If yes, what color? __________
Size of Abnormality _________
Mobile? Y/N
Location _________________
Skin Changes Y / N

Vulva: ( ) Normal ( ) Other: ______________________



Vagina: ( ) Normal ( ) Discharge:
( ) Scant ( ) Moderate ( ) Profuse
Describe: ___________________________
PH: ________________

Cervix:
( ) Normal ( ) Lesions ( ) Ectropion
( ) Discharge: ___________________



OS: ( ) Round ( ) Transverse ( ) Lacerated
( ) Contact Bleed ( ) Yes ( ) No
CMT ( ) Yes ( ) No

Uterus:
Position: ( ) Anteverted ( ) Retroverted ( ) Mid ( ) Other
Consistency: ( ) Firm ( ) Hard ( ) Soft ( ) Mobile ( ) Nontender
Contour: ( ) Smooth ( ) Regular ( ) Nodular ( ) Fibroids
Size: ( ) Normal ( ) Small ( ) Enlarged _____________
Other Findings: _____________________________

Adnexa: Right _____________ Left __________________
Rectal: ( ) Normal ( ) Abnormal ( ) Deferred
Impressions:

Counseling/Education (√ if verbal, o if written)
□ HIV/STD Counseling
HIV test refused today Y/N
□ Smoking Cessation
□ Assessment/Plan Discussed
□ Lab Findings
□ Alternative Method Advised:
____
□ Current Contraceptive Reviewed
□ Nutrition
□ Exercise
□ Coercion Counseling
□ Domestic Violence
□ Sexual Abuse
CIIC/CI Provided
□ Method Specific _________________
□ CDC Fact Sheet Given _____________
____
□ Medication FS Given ______________
____
□ Breast Referral CI Given
□ Other: _________________________

□ Family Planning/Birth Control Discussed
□ Patient Advised to RTC for Well Woman/Pap
□ Patient goes to Pvt MD for GYN care

LABEL

Medication Rx: ____
Referral: ________________________________ □ NIPIE______________
Return Visit: ____________________ For: _______________ With: ( ) MLC ( ) RN ( ) MD
Clinician's Name (print)________________________Clinician's Signature ________________